

# Outreach to People Experiencing Homelessness

A CURRICULUM FOR

TRAINING HEALTH CARE

FOR THE HOMELESS

OUTREACH WORKERS

by Ken Kraybill, MSW

NATIONAL  
HEALTH CARE  
*for the*  
HOMELESS  
COUNCIL

# Outreach to People Experiencing Homelessness

A Curriculum for Training  
Health Care for the Homeless  
Outreach Workers

Ken Kraybill

National Health Care for the Homeless Council  
and  
Health Care for the Homeless Clinicians' Network

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## Acknowledgements

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You have taught me about survival and hope. You have reminded me that “it’s the little things that count” in how we treat one another. You have demonstrated amazing grace and perseverance in the face of extreme poverty, severe mental illness, addictions, and medical conditions. And you have demonstrated the courage to make positive changes despite the odds.

Many others have contributed to this endeavor – colleagues with the National Health Care for the Homeless Council, with the Health Care for the Homeless Clinicians’ Network, and past and present co-workers in the Health Care for the Homeless Network in Seattle. In addition, my sincere thanks to those of you who are program administrators, organizers, writers, researchers, policy-makers, advocates and others who work and speak out on behalf of people experiencing homelessness. I also wish to acknowledge my faith community that has “held” me, kept me grounded, and inspired me through the years to be “foolish” enough to continue working for peace and social justice.

In particular, I am indebted to Craig Rennebohm with the Mental Health Chaplaincy in Seattle, who has been a guiding light for me over the years. His influence is deeply embedded in this curriculum.

Special thanks to Jean Hochron at the Bureau of Primary Health Care for advancing the idea and supporting the development of this curriculum. I am also very grateful to Marsha McMurray-Avila for her creative and wise counsel in shepherding me along the way. Thanks to John Lozier for your steady hand of support. And kudos to Al Lucero for going through the tedium of mounting the curriculum on the web and dealing with my various foibles.

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## Introduction

**"We are called to heal wounds,  
to unite what has fallen apart,  
and to bring home those who have lost their way."**

**St. Francis of Assisi**

**"For me, outreach begins and ends with an understanding  
of healing as a movement towards wholeness."**

**Craig Rennebohm**

This curriculum is written on behalf of the members of our human community who wander our city streets, live in wooded areas, dwell under bridges, and otherwise inhabit the edges of the landscape of our lives. It is written especially for those individuals for whom homelessness is not a transitory experience, but has become a fixed condition. These people, our neighbors, experience severely disabling conditions and face seemingly impervious structural barriers in moving from the street to stability. They are the ones for whom hope is a distant dream.

The curriculum is designed to be used by any person or program involved in reaching out to people experiencing homelessness. Parts of the curriculum are specifically oriented to those working in federally-funded Health Care for the Homeless (HCH) projects throughout the United States. This national HCH program "emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy." <http://www.bphc.hrsa.gov/homeless/>

HCH workers go out to shelters, into the city streets, wander into wooded areas, poke their noses under bridges, and seek out those people who live in our midst, but who too often are "hidden in plain sight." Outreach workers are the ones who help build trust and hope, overcome barriers, and bring care to people experiencing chronic homelessness. The intent of this curriculum is to prepare and equip outreach workers for this compelling and challenging work.

Chronic homelessness is a real life drama about being caught among the forces of extreme poverty, a lack of access to adequate resources and services, the experience of illness and disability, and feelings of estrangement from self and community. It is a drama with a cast of tens of thousands, a true American tragedy.

Chronic homelessness unrelentingly erodes the human spirit and will, causing individuals to become increasingly entrapped in feelings of hopelessness and diminished self-worth. It forces men, women and children into a daily struggle for survival and robs them of the ability to live more full and meaningful lives.

The overarching goal of outreach is to help break the bonds imposed by homelessness. Outreach, at its best, helps people move toward a life of greater health and personal stability. In so doing, they are able to discover more fully their own sense of identity and purpose, find meaningful work and activity, and establish a sense of place and belonging in the larger community.

Outreach to people experiencing homelessness is about being a neighbor in a radical way to those who are "strangers in the land." It is about compassion translated into concrete action. It is about regarding all human beings as intrinsically valuable. For some, outreach is an outward expression of their work for social justice. For others, it is simply about doing what is right. Yet for others, it is envisioned as helping to bring healing to people broken in body and spirit, and making strangers into friends. Outreach is about all these things, and more.

In the early stages of writing and assembling this curriculum, I came across this quote by Albert Einstein: *"Everything should be made as simple as possible, but not simpler."* I've attempted to make this a guiding principle in my work. In identifying and describing the various aspects of doing outreach, I've tried to present the content in an accessible way. But I've also been wary about succumbing to oversimplification. It has been said that human relationships, which are fundamental to outreach, are among the most perplexing challenges we will ever encounter in our lives, perhaps even more confounding than "rocket science!"

In many respects outreach appears compellingly simple. To the untrained eye, outreach workers are "human kiosks" who strategically position themselves in the community to dispense information and make referrals. If only it were that simple! What is unseen is the involvement of the outreach worker in the careful and painstaking process of building a bond of trust with human beings who are profoundly distrusting. Such a trust relationship is, of course, the necessary foundation upon which all other outreach activities are based.

To provide outreach services effectively, there is a great deal of preparation to be done. This requires careful inner work as well as extensive outer preparation. The worker must be aware of what he or she brings to the work in regard to his or her own strengths, style, challenges and vulnerabilities. The worker must also have knowledge and competency in multiple arenas.

Too often, outreach workers have received inadequate training and have been put out on the streets literally to "learn by experience." While this "shoe leather" approach to learning can indeed be an effective teacher, it is often both insufficient and inefficient.

The intent of this curriculum is to help workers gain a fuller understanding and appreciation for outreach work. There is no set formula, but it is hoped that by exploring the process and content of outreach from a variety of perspectives, workers will become more effective in their efforts to assist people toward greater stability.

At one level, the curriculum attempts to outline the minimum basic training and knowledge requirements that all outreach workers must possess. At another level, its intent is to help workers develop increased self-awareness, empathy and interaction skills in order to use their knowledge effectively.

Outreach activity engages one's whole being. It touches us at many different levels of human experience. The work of outreach can be very difficult to put into words because language is often limited in describing the "realness" of the experience. Sometimes, as singer/songwriter Bruce Cockburn says, "Those who know don't have the words to tell; those with the words don't know too well."

The subtlety of a gesture, a small step risked, the joy or despair on someone's face – these cannot easily be described with language. Perhaps this is why many outreach workers find that music, poetry, dance or silence best describes their daily experience. Hopefully, this curriculum will allow you to touch and help transform many lives through your outreach efforts, and in turn be touched and transformed personally by the work itself.

## **Why the Need for an Outreach Curriculum?**

Is there truly a need for a curriculum to teach people how to do what people have been doing since the beginning of time – interacting, encouraging and providing help to one other? It appears the answer is yes, especially when it concerns people experiencing homelessness.

Unfortunately, in a culture in which the values of individualism and self-reliance hold sway, these natural inclinations and capacities to help seem to have diminished. This is particularly true as people experiencing homelessness have been increasingly pushed towards the extreme margins of community life. In a world that has become increasingly complex, disparate and unsafe, so has the ability to care for one another become more difficult. Thus, the need for specially designated workers to reach out and connect with those on the edges, in order to bring them closer to the center of care and life in the community.

Outreach is central to the Health Care for the Homeless approach to care. As outreach work has become increasingly recognized for its importance, there has also been an acknowledgment of the need for workers to be trained regarding the core values, knowledge, and practices involved in effective outreach. While learning by experience is invaluable, there is much to be said for learning from the experience, including the successes and the missteps, of others.

The complexities and risks inherent to outreach work require that workers be well prepared. In addition to increasing knowledge and enhancing skills, proper training can help workers address issues of power, intrusion, and coercion and promote the value of approaching others with respect and humility.

As the practice of outreach in the HCH setting has evolved since the mid-1980s, so too has the understanding of how to do effective outreach. It is this learning that provides the foundation for this curriculum. As knowledge continues to advance, insights are gained, and approaches modified, it is hoped this new learning will be incorporated into this curriculum through regular revisions, thus making it a dynamic, living resource.



## **Purpose and Scope of the Curriculum**

The purpose of this outreach curriculum is to provide a comprehensive overview of the principles, knowledge, and issues relevant to doing outreach in the Health Care for the Homeless context. In addition to providing information, it is intended to engage the participant by using various modalities and activities that appeal to different learning styles.

As with any curriculum, this particular one won't meet "all the needs of all the people all the time." In HCH programs throughout the country, outreach activities are practiced by clinicians with differing backgrounds and experience, in settings that are varied geographically and culturally, and that provide an array of services targeted to different sub-populations of homeless people. Thus, the training needs of workers in each program will differ and must be tailored to the individual worker as well as to the specific goals of that program.

It is anticipated that workers will have been thoroughly oriented to their respective agencies prior to receiving the training outlined in this curriculum. Trainees should be familiar with the agency's mission and goals, personnel policies and procedures, relevant contracts and collaborative agreements, supervisory structure, their own job description, data collection and documentation requirements, code of ethics, grievance procedures, and other relevant information specific to their job.

In addition, this curriculum presupposes that trainees will have received training specific to relevant laws, statutes and requirements that govern their practice. Because each state and locale varies in regard to its social and health service structures and laws, much of the training that outreach workers require will necessarily be locale-specific. For example, financial programs and entitlements can differ greatly from state to state. The same is true for involuntary commitment laws for mental health and substance abuse.

## How to Use this Curriculum

This curriculum is intended to serve as a guide for anyone involved in facilitating training for outreach workers in Health Care for the Homeless settings and other outreach programs. It is anticipated that non-HCH programs and clinics providing outreach to homeless people will find it to be a valuable resource and adapt it as needed.

It is envisioned that the curriculum will be used primarily in local settings for orienting and training outreach workers. Thus, local issues, case examples, sites, and resources can be incorporated into the training to make it as relevant as possible. The curriculum will also prove to be a useful resource for providing outreach training at regional and national levels.

The curriculum is designed for use with small groups or teams of persons involved in outreach. It can also be used with larger groups, for example, with outreach workers from various agencies in a particular city or region. While it could be used conceivably with one or two individuals at a time, as in a new employee orientation, it is likely to be more effective when taught within a group context where ideas, perspectives and experiences can be shared among participants.

There are a number of ways this curriculum might be used to benefit HCH programs and workers:

- To orient and train newly-hired outreach workers
- As a resource for in-service/continuing education sessions within an agency
- To bring together outreach workers from various community organizations for training and networking
- To review, and possibly rewrite, job descriptions for outreach workers
- To create a mission statement for an outreach program
- To use the curriculum resource papers and handouts to create or contribute to an "outreach library" in the agency
- As a self-study guide for individual workers
- To use selected hand-outs taped on refrigerators, doors, walls as reminders for workers
- To "train trainers" in using the curriculum to teach others about outreach
- To use for writing grants and position papers
- To inform education and advocacy activities regarding resources and policy changes
- To try to explain to your family and friends "what you do"

Facilitators who plan to use this curriculum will find that some aspects of it resonate well with their personal teaching style while other sections may not engage their attention so readily. This is to be expected. Because it is important for instructors to "own" the material they're teaching, it is encouraged to view the

curriculum as a set of resources from which to draw. It is anticipated that trainers will utilize what works well for them and adapt other approaches as needed.

Experiences, stories, and anecdotes are seen as integral to making this material come alive for trainers and for participants. Trainers should share their own experiences liberally and also draw upon those of participants. It is equally important that facilitators rely upon a teaching style that is within their own personality and comfort zone, in which they inject their own unique sense of humor, and relate to others in the ways that are comfortable.

The curriculum has been written so that the content and flow of material constitutes a comprehensive package. It is designed to be taught in its entirety. However, it is recognized that this may not always be feasible. In such cases, it can be approached as a menu from which various entrées can be chosen. Instructors can select those learning topics and activities that are most relevant to the group and that fit within the training time allotted. Preferably, this will be done in consultation with the training participants themselves.

It is also acknowledged that this curriculum cannot cover the training aspects of outreach that are specific to a certain organization and locale. For example, knowledge of agency policies and procedures, local service organizations, targeted outreach areas, cultural characteristics, and other unique features of the locale are obviously an important part of any orientation and training. Nor does the curriculum pretend to provide the education and training needed to understand the myriad medical and psychiatric conditions encountered in outreach.

## Thoughts and Tips for Facilitator-Trainers

Tell me and I'll forget  
Show me and I'll remember  
Involve me and I'll understand

**Confucius**

The Merriam-Webster meaning of the word *facilitate* is “to make easier: help bring about.” Thus, the role of a facilitator-trainer in this particular context is to make it easier for participants to learn what it is they need to know and understand about outreach. The intent of this section is to provide some ideas to take into consideration as you prepare for providing training. Begin by taking the self-quiz below to learn about “Facilitating Made Easy.”

# Facilitating Made Easy

By Valerie Sokolosky

*A good teacher must be able to engage people and encourage participation. Take this quiz to check your skills.*

1. **Above all, training session participants want to:**
  - a. Have fun at the meeting.
  - b. Learn practical applications.
  - c. Take good notes.
2. **The quickest way to build rapport with participants is to:**
  - a. Mingle with them before the session.
  - b. Have interesting information about the course posted on the walls.
  - c. Know everyone's name ahead of time.
3. **You should start the program with:**
  - a. Everyone stating their names.
  - b. Showing your first visual on the screen or flip chart.
  - c. Getting participants involved.
4. **Start-up activities can involve an icebreaker or opener, which are:**
  - a. Different in the amount of time needed to use them effectively.
  - b. Intended to ease people into the program.
  - c. Used to provide fun at the session's start.
5. **As a facilitator, you set the right climate by:**
  - a. Making sure the room temperature is comfortable.
  - b. Having pencils and paper at each place setting.
  - c. Positioning yourself competently both verbally and physically.
6. **If people are missing when it is time to start the session, you should:**
  - a. Start the meeting on time anyway.
  - b. Point out that you're starting on time even though people are late.
  - c. Give latecomers an extra 10 minutes to arrive before you start.
7. **If you use skill assessments, remember that they:**
  - a. Usually require that people have high intellectual capacity.
  - b. Are basic tools for experiential learning.
  - c. Should be used only in management sessions.
8. **Skilled facilitators must be able to:**
  - a. Think quickly on their feet.
  - b. Tell good jokes.
  - c. Speak loudly enough for all to hear.
9. **Since most programs will include a diverse group of people, you should:**
  - a. Plan to use a variety of methods.
  - b. Know the ethnicity of your group.
  - c. Find out ahead of time if you need to speak slowly.
10. **Advantages of pre-meeting assignments include:**
  - a. Getting people in the habit of reading.
  - b. Showing people that this subject needs advance thinking skills.
  - c. Setting a professional tone for the course.

(Answers on next page)

# Facilitating Made Easy

## *Answers to Quiz*

1. **b.** Participants don't wish to attend training sessions without taking away valuable ways to help them be more effective.
2. **a.** Be relaxed and ready to greet people as they arrive. Your smile and welcome before the meeting go a long way toward creating a positive attitude.
3. **c.** You often will have large groups of people, and it would take too much time for verbal introductions. There are better ways to get them involved at the beginning, but *do* get them involved.
4. **b.** Both icebreakers and openers are start-up activities to help engage people at the beginning of the program. Icebreakers are relatively subject-matter free. Openers are directly related to the content of the session. An icebreaker might have participants in small groups make introductions so they could get to know one another.
5. **c.** Where and how you position yourself is significant. Give enough information about yourself to gain people's confidence in you as an expert. Stay in front of the group; if you stand behind a table or podium, the audience might be inhibited.
6. **a.** If your meeting time was posted, you should begin on schedule. You can tell those who are late that you will help them catch up during a break. It's rude to keep others waiting, and you will lose credibility if you don't start on time.
7. **b.** Assessment instruments are useful for generating data that people at all levels can look at to enhance effectiveness. An example would be a list of questions assessing one's listening skills, rated on a scale of 1 to 10.
8. **a.** Interested participants will want to know answers to questions you may not have included in the course. They also might have strong opinions you will need to address. Experience and knowledge are your best friends.
9. **a.** Diversity means different learning styles and preferences, as well as various ethnic groups or gender differences. Include in the session visuals, writing, group discussions, and activities.
10. **c.** These assignments set the tone for an active course atmosphere, not only a lecture format. People will know their participation is important.

(Reprinted courtesy of Southwest Airlines Spirit magazine.)

## **The Learning Environment**

- Pay attention to the training/learning setting. Create a hospitable environment that is welcoming and friendly. Envision it to be more like a retreat setting than a traditional classroom.
- Choose a space with good lighting, heat and ventilation. Arrange the seating in a manner that is conducive to easy dialogue. Circles work well as does the use of round tables. Provision of some light food and drink is always recommended.
- For those who need something to do with their hands, provide items such as different colored pipe cleaners, modeling clay, little plastic animals, or other toys. Not only will this help some people pay attention, but also some very interesting art will be produced!
- Use the streets or shelters as your learning environment if possible. Include a walking tour or a windshield tour of the outreach territory. There is no better substitute than this "in vivo" approach. For a newer outreach worker to be able to accompany and observe a more experienced outreach worker in action is also invaluable.

## **Plan and Approach**

- In your own experience, what have been the characteristics of an effective teaching and learning environment? Place yourself in the role of the participant as you plan.
- Adults learn best when they are relaxed and engaged. Be creative and even playful in your approach. Make the material "come alive."
- Remember two fundamental questions participants will bring to the training: "Will I be safe to participate in this group setting without being ridiculed, ignored or 'shot down'?" "Will I be seen as someone who can contribute something of value to this training?" (Nora-Joanne Gerber, from workshop on "Getting the Message Across")
- Plan how you will incorporate cultural competency concerns for each module. Use illustrations and case examples that address cultural issues and implications of the work. Make cultural awareness an integral thread woven through the outreach training.

- Plan in a way that ensures participants come away with practical knowledge and skills.
- People, younger and older, learn best by doing. As the adage goes: "Tell me and I'll forget. Show me and I may remember. Involve me and I'll understand!" (Confucius)
- Take time to prepare adequately for each topic. Interact with the material and make it your own. Otherwise, the training will be a rather dull experience for all involved.
- Use the curriculum as a guide, not a prescription. Draw from it but don't rely totally upon it. Incorporate your own style, your stories, your playfulness, and your personal experience into your teaching.
- In structuring the training, emphasize learning from and with each other as a group. Incorporate ample opportunities for participants to interact, discuss, and present their views. Try to limit didactic teaching approaches to 20-25% of the time used.
- What teaching methods keep your attention best? Intersperse your teaching with well-formulated and thought-provoking questions. Such questions accompanied by open dialogue stimulate the learner's engagement with the topic at hand.
- When presenting material, vary the teaching methods and media you use for different topics. People have different preferred learning styles (e.g. auditory, visual, kinesthetic). Most of us benefit from the combined use of all of these styles.
- Common teaching methods include: verbal presentations, use of overheads or slides, videos, individual reflection, worksheets, conversation/discussion with partners or small groups, large group discussions, visual arts, music, drama, and role-playing. Often the group will let you know what methods work best for them.
- Use a variety of presenters as much as possible. This may include homeless people, other outreach workers, people with specialized experience or training, and training participants themselves. Ideas that come from a variety of "voices" enrich the material and perspectives presented. This also keeps things interesting for participants.



## **Your Role**

- Remember your role as a facilitator-teacher. Continue to seek ways to “make it easier” for participants to learn.
- Freely contribute from your own experiences and expertise, sharing mistakes from which you have learned, as well as your successes.
- Permit yourself to be a co-learner. We have much to learn from one another despite our formal training or level of experience. Demonstrate and promote an attitude of openness to mutual learning. In the arena of outreach, as in life, none of us know it all, need to know it all, or need to give the appearance of knowing it all.

## **General**

- Learn to know the specific learning needs and interests of individual participants. Your teaching emphasis can then be tailored accordingly.
- It is quite beneficial to incorporate a focus on mentoring relationships for participants. A mentor provides a one-to-one relationship to provide support, information and counsel. Certainly, supervisors play a mentoring role, but others, including peers, can perform this role as well.
- Learn to know the participants as individuals whose lives extend beyond being outreach worker trainees. Appreciate the characteristics, interests and style each brings to the group.
- Repetition is a good thing. Not only should you not be concerned if things get repeated several times, you should plan to repeat certain key concepts. Remember that adult learners typically need to hear something 6-7 times to have it sink in. Repetition is a good thing.
- Build in times during the training for “stepping back” and reflecting on both the content and process of the training. Ask questions of the participants. “What has especially caught your attention thus far?” “What new ideas are being raised for you?” “Are your specific training needs being addressed?” “Are we focusing on the right things?” “How is the pace?”
- Incorporate awareness throughout the training of the emotional aspects of this work – both the draining and the inspiring parts. Acknowledge the inherent stresses of doing outreach and the importance of giving regular attention to self-care and renewal.

# **Module 1: INTRODUCTION**

## **UNDERSTANDING THE BASICS OF OUTREACH AND HOMELESSNESS**

### **Purpose**

The purpose of Module 1 is to introduce participants to the Relational Outreach and Engagement Model, to provide an overview of the history, philosophy, and services of the federally funded Health Care for the Homeless (HCH) Program, to describe the various characteristics of outreach in the HCH model of care, and to examine the realities and experience of homelessness.

# 1A: Introduction and Overview

"You got to be careful if you don't know where you're going,  
because you might not get there."  
– Yogi Berra

## **Purpose**

The purpose of this section is to kick off the training in a positive manner, help participants connect with one another, and introduce the general topics that will be covered in the training.

## **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## ACTIVITY 1 Welcome and Opening Exercise

Purpose: To welcome everyone, make brief introductions, and engage in an opening exercise that accentuates the importance of listening in outreach.

Time: 15-25 minutes

Materials: None

### Preparation:

Review the preface section to the curriculum, especially the Tips for Trainers section. This will provide a backdrop to your approach to the modules, providing reminders about setting up the learning environment and creating a positive tone for the training.

Remember the curriculum is a guideline, not a prescription. Adapt it in such a way that it works for you and for your audience. Let the curriculum material engage you so that you will be able to present the material in a manner that engages others.

### Procedure:

1. Greet participants as they arrive. Start on time and welcome them to the training. If the space is unfamiliar, note where the bathrooms are and other information about the facilities. Invite everyone to partake of refreshments if they are being provided (always a good idea!).
2. As needed, briefly introduce yourself and have others introduce themselves.
3. Explain to the group that the opening exercise is designed to help people become better acquainted with one another. It also involves two of the most important aspects of outreach: *story* and *listening*.
4. Have everyone find a partner and sit where they can converse and have some privacy from others in the group.
5. Each partner is given three to five minutes to tell a story from personal experience that starts with ***"I want to tell you about the time when ....."*** (Alternatively, story-tellers might be invited to give a brief chronology of their life, recount a particularly significant event they experienced, tell about an influential person, or talk about future aspirations.)
6. As one partner shares, the other listens attentively but without verbally responding or interjecting her/his own thoughts. The listener's task is simply to listen well. Non-verbal responses such as nods and knowing smiles are permitted, but no words.

7. After the speaker has finished, the listener is to respond by summarizing what he/she heard. This summary, a form of reflective listening, should be brief, attempting to communicate the "core information and meaning" of the message.

8. Partners then switch roles and proceed in the same manner as described above.

9. Bring the group back together and invite comments on what this experience was like both from the perspective of the teller and that of the listener. Often, listeners will report on how difficult it was to refrain from making comments. Typically, tellers will report how nice (and rare) it was to be listened to so attentively.

## **ACTIVITY 2 Curriculum Overview**

Purpose: To familiarize participants with the “roadmap” for the training and to decide with the group where to place the most time and emphasis along the way.

Time: 10 minutes

Materials: Handout: Outreach Curriculum Outline

Preparation: Review the curriculum outline so you are familiar with it.

Procedure:

1. Provide each participant with a copy of the curriculum outline handout. Lead them on a brief tour of the outline as a whole, or at least the parts of it that you intend to cover during the course of the training. This will help orient them to the “big picture” of the outreach training. If you were a photographer, this would be the panoramic shot using a wide-angle lens.
2. As you describe the topics to be covered, determine from the group which areas are of particular interest to them. This information can help you gauge where to put extra emphasis as you proceed through the training. Training is most effective when it is tailored to the needs of your particular audience.

# **OUTREACH TO PEOPLE EXPERIENCING HOMELESSNESS**

A Curriculum for Training  
Health Care for the Homeless Outreach Workers

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June 2002

## **Curriculum Outline**

### **Preface**

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Community Resources and Services  
Effective Referral and Linking  
The Outreach Worker as Advocate

#### **Module VI Mutuality – “Coming Home”**

The Meaning of Home  
Three Homes  
Transition and Closure

### **Appendix**

### **ACTIVITY 3 The Relational Outreach and Engagement Model**

Purpose: To introduce the Relational Outreach and Engagement Model (ROEM) which provides a framework for the structure of the curriculum and its content

Time: 30 minutes

Materials:

Resource Paper: Relational Outreach and Engagement Model

Handout: Relational Stages of Outreach and Engagement

Handout: Relational Outreach and Engagement Diagram

Handout: Activities along the Outreach and Engagement Continuum

Handout: He Sat Slumped on a Park Bench ...

Preparation:

Read the resource paper and handouts. Familiarize yourself with the ROEM model. Note the characteristics and specific activities associated with the four stages represented in the model. The handout, "He Sat Slumped on a Park Bench ...," provides a case illustration of movement through these stages.

In addition, think of an outreach case example with which you are personally familiar and reflect how it developed through the relational phases as described in the model.

Note that these relationships seldom develop in a smooth, linear fashion. Some never make it beyond the approach phase. Relatively few make it to the mutuality stage. Movement into the partnership stage might take a little time or a very long time depending on client readiness and resource availability. Be sure to emphasize that this is not a static model when presenting it to the class.

Procedure:

1. Refer participants to the handouts: Relational Stages of Outreach and Engagement, Activities Along the Outreach and Engagement Continuum, and the ROEM Diagram. Give a presentation on the content in these handouts that describe the four stages of the Relational Outreach and Engagement Model and the outreach worker's activities associated with each stage on the continuum.

2. Next, have someone read aloud the case example in "He Sat Slumped on a Park Bench ..." Use this outreach encounter to illustrate and discuss the relational phases in the Relational Outreach and Engagement Model.

3. Ask for case examples from the group that might illustrate some or all of these stages of the outreach relationship.

4. Provide some time for discussion and questions. Note that the model itself will be explored in greater depth throughout the course of the training.



# Relational Outreach and Engagement Model

Adapted from unpublished papers by  
Craig Rennebohm, Mental Health Chaplaincy

The **Relational Outreach and Engagement Model (ROEM)** provides a theoretical framework for understanding the outreach and engagement process, offers specific practices appropriate to each stage of the work and suggests benchmarks by which movement along the outreach and engagement continuum of care can be assessed. In the ROEM view, life has a profoundly relational character. The implication for outreach is not whether one can establish a relationship with another, but rather how will any given relationship develop and take shape from moment to moment over time.

For teaching purposes the outreach and engagement process is envisioned in four phases: **approach, companionship, partnership and mutuality**. Each phase is marked by a predominant quality in the emerging relationship as seen from the perspective of the outreach worker and the experience of the homeless individual. The model is a theoretical ideal. It is not intended to suggest that the outreach and engagement process flows in a neat linear progression or that the four phases are discrete, clearly bounded stages.

In practice the relational field in which the outreach worker and the homeless person move is extraordinarily complex and filled with many subtleties and unknowns. Outreach is necessary precisely because the more general and generic processes by which people come into care (referral, appointment, walk-in, screening, intake etc.) have not proven successful in leading to treatment.

Outreach and engagement practice seeks to build a relationship of trust and care with those who present unusual challenges and are the most difficult to serve. The process can take days, weeks, months, even years. The outreach worker must be present in a variety of ways with the individual, in brief moments and over long hours, on an unpredictable schedule, as the person is ready. While this model has a certain simplicity and elegance, it is an abstraction from the many earthy, involved steps which lead from the street to stability.

The Relational Outreach and Engagement Model provides an orientation to the challenges before us. It is a reminder, in the midst of the difficulties of practice, that we are involved in a complex but ultimately hopeful process.

Isolation and distance characterize the relational field of the homeless individual without care. The individual has few and minimal interactions with others. In the **approach** phase the outreach worker honors the tentativeness of the relationship. This phase is marked by the intention of the outreach worker to be present, and to weave, if possible, a fabric of connection, thread by precious thread. Meetings are random, spontaneous, loosely planned. Visits are brief, with

little or no agenda. The role of the outreach worker is at its most diffuse -- neighbor, a caring observer, a passerby willing to stop and listen.

In the approach phase, specific activities are minimal -- a smile, a nod, an inquiry, a brief offer to help, a cup of coffee placed beside the person. No one thing and many little things embody the outreach intention. The worker waits carefully for the smallest sign, the littlest hint of a response. No one moment suggests that we are making progress. There are setbacks, pauses. These too are part of the process. Our occasional notes reflect the tenuous nature of the work. "Saw John at Westlake Park, said hello." A week or two or more of no contact. Another brief encounter.

The transition from the approach to **companionship** phase occurs as the outreach worker offers and is permitted to share the subject's journey. The worker is recognized, greeted, welcomed. In this phase the outreach worker is experienced as an increasingly trustworthy and established dimension of the person's life in the world, something of an anchor point if you will.

In the companionship phase the outreach worker provides a reliable presence, listens to the person's story, offers empathy and acts with knowledge and proper timing and in response to the individual's issues and concerns. The worker is attuned to the individual's current situation, how they see themselves, their perceptions of the world around them, and their ability to meet needs for care, safety and survival in the midst of homelessness. Personal strengths as well as deficits are noted. The presence of a physical, mental and/or substance abuse disorder might be observed and assessed.

Benchmarks of companionship include time spent walking or riding together, agreement on a regular meeting place and sharing hospitality moments such as a cup of coffee or a meal together. It may include a small task shared, help with some necessity, going together to check out a resource such as a drop-in center or shelter, or any of a hundred activities. No one instance determines the beginning of the companionship phase. A series, an accumulation of occasions together suggests the shift from approach to companionship is being accomplished. The dyad is growing stronger.

In the course of companionship there are increasing opportunities to introduce the homeless person to others who can assist in the journey from the street to stability. Key to the transition from companionship to **partnership** is the capacity of the outreach worker and the individual to open their relationship of trust to include a significant third party - a social worker, case manager, nurse, doctor or counselor who offers specific support for the person. The partnership phase is marked by the individual's acceptance of a growing circle of care in which the triad of subject, outreach worker, and a primary care provider form the core. The outreach worker's companionship role continues to be critical in this phase to

provide a trustworthy presence, information, and encouragement to the homeless person who is connecting with other providers and services.

The outreach and engagement process is completed as the worker and subject move into a phase of increasing **mutuality**. It is precisely the growing, common human bonds which the worker and individual share which permits the relationship to be brought to fruition and eventually to an appropriate termination. The worker celebrates with the individual such basic experiences as making a home, developing a daily routine, discovering arenas of work and recreation. In this context of a real and growing life with others, the worker prepares for separation and the transition into ongoing journeys along clearly differentiated paths.

In a relational model, outreach and engagement begins with an approach to the homeless person based on an affirmation of our common humanity and the possibility and potential for relationship. At the heart of companionship is a trustworthy dyadic relationship. In partnership a triadic relationship emerges at the core of the process. The final phase of the relationship is marked by the multiplicity of relationships, a sense of neighborhood and community in which the subject has a healthy sense of self and place.

# Relational Stages of Outreach and Engagement

Craig Rennebohm

Outreach and engagement is the process of coming along side of someone who is struggling with homelessness and related health and social concerns, and sharing the journey in a way that leads to healing, wholeness and stability in the community. Outreach and engagement activities can be seen as a movement through four phases of relationship: approach, companionship, partnership, and mutuality.

**Approach:** The approach phase involves observation and introduction. It is helpful to spend time simply watching, to see how a person acts, how they relate to others, what kind of space they need, how they seem to be experiencing their environment and responding to the world. Careful observation helps us shape an introduction. We may simply pass by with a nod or greeting, the most minimal of neighborly acknowledgments. We may introduce ourselves in a general way, or with a more specific role and concern. The key is to begin generally as someone who cares, and define our role more specifically as the relationship develops and trust builds between us.

**Companionship:** At its simplest, companionship means sharing a little of the journey with another, standing or sitting with them, walking a little ways with another, listening, and hearing a person's story. Perhaps it may include suggesting some possibilities to assist someone along the way, maybe going with them to some destination, or arranging for another to accompany and help them.

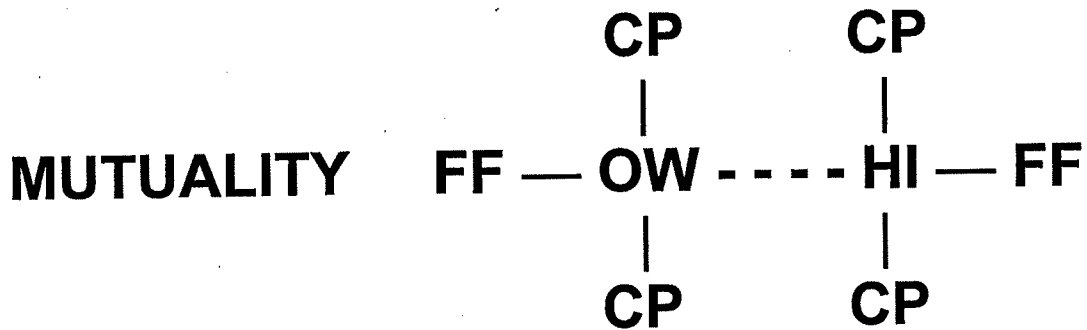
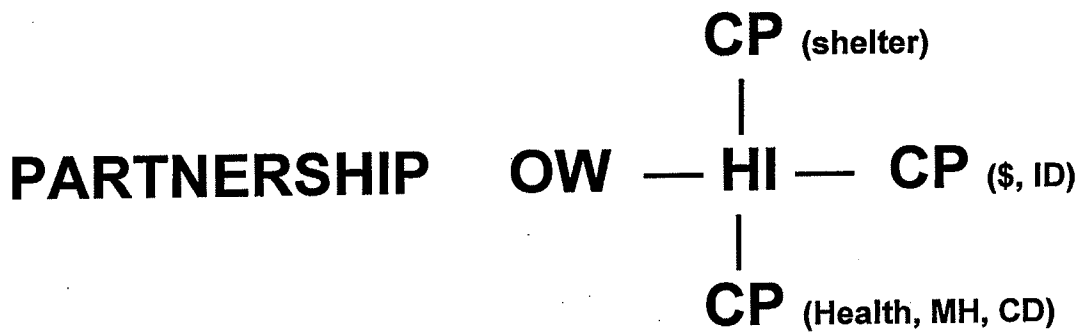
**Partnership:** The partnership phase of outreach and engagement begins when we introduce the person to others who can help or assist. In partnering with others – case managers, medical providers, social service programs, family members – a widening circle of care is created upon which the individual can rely for support and care in various aspects of their lives.

**Mutuality:** In the phase of mutuality, we recognize one another as fellow citizens and community members. We continue to encourage the other in making use of appropriate resources for their journey and support the individual in becoming a stable part of the neighborhood and community. In time, it is recognized that the relationship has come to fruition and thus is brought to closure as appropriate.

# Relational Outreach and Engagement Diagram

**APPROACH**      OW → - - - - - HI

**COMPANIONSHIP**      OW → ---- ← HI



OW = Outreach worker  
CP = Community Provider

HI = Homeless Individual  
FF = Friends, Family

# Activities Along the Outreach and Engagement Continuum

## ***Approach Activities***

Observation-assessment – Worker observes homeless individual to assess behavior, basic needs, and level of functioning.

Observation-planning – Worker observes to determine method of approach that appears to fit best within individual's comfort zone.

Introduction – Worker approaches person and introduces him/herself by name (homeless person may or may not respond). Worker may choose to identify self in general terms initially, for example, as a fellow human being, neighbor, person who does outreach in the community.

Worker greets homeless person – Worker greets person only (a nod, hello), no additional conversation.

Casual conversation – Worker speaks informally with homeless person not specifically related to services or needs. The worker's intent is to build a relationship and increase person's comfort level.

Assistance from others – Worker seeks assistance from other people in approaching the homeless individual. This could be a family member, friend of the person, shelter worker, store keeper, etc.

Identification of self in specific role – Worker identifies self in specific role by discipline or title, who works for local Health Care for the Homeless project that provides services such as HIV/AIDS, chemical dependency, mental health, youth, women, elderly, sex workers, etc. Seen as significant transitional point to companionship phase.

## ***Companionship Activities***

Hearing story – Worker listens to client's concerns, wishes, history, perceptions, feelings, etc.

Activity together – Worker and client engage in activity together, e.g., have a cup of coffee, go for a walk, eat a meal, or other relationship building activities.

Identification of client's perceived needs – Worker and client jointly identify the client's self-perceived needs.

Client given something to relieve situation – Worker gives client a tangible object such as food, a blanket, hygiene kit, etc.

Client accompanied by worker for short term/survival services – Worker goes with client to appointment or to receive services such as food, shelter, or clothing.

Assistance with short term/survival services – Worker provides information and referral assistance to client to improve her/his immediate situation.

Emergency intervention – Worker intervenes in emergency situation in which client's life or health is at risk, or the situation is in danger of escalating out of control.

Client contacts worker – The client initiates contact with worker, approaching worker in person or contacting him/her by phone or message.

Worker and client meet in public agency venue – Client is able to tolerate meeting with worker in a setting with some structure such as a drop-in center, shelter, restaurant, etc. This could also be an office visit. This is seen as a transitional point to partnership.

## ***Partnership Activities***

Identification of mutual goals (longer term) – Worker and client mutually identify goals to address (e.g. obtaining ID, health care, dental, mental health /substance abuse treatment, entitlements, work, housing, education, etc.)

Plan for meeting goals (longer term) – Worker and client develop a plan together to achieve goals.

Information about services – Worker provides client with information on services and/or care providers that worker believes will facilitate goal accomplishment.

Worker and client meet with longer-term service provider(s) – Worker, client and service provider meet to discuss client's needs/goals. Provider takes a lead role in assisting client with specific goal achievement.

Worker transitions into role as longer-term provider – Worker moves into a case management role, client is engaged.

## ***Mutuality Activities***

Client meets with other service provider without outreach worker present – Worker's role gradually becomes more secondary as client able to establish working relationship with other providers.

Worker makes outside referrals, arranges appointments, negotiates services – Worker continues involvement by supporting client and facilitating services on client's behalf.

Worker advocates for client within new support systems – Worker continues to reinforce bridge between client and long term service system. Advocates for client within service system. Re-engages client and service system as necessary.

Client meets with worker to process client's work with long term providers – Worker remains in supporting role, reinforces goals, listens to client concerns, etc.

Worker monitors client progress in case management – Worker moves to the background, but remains in periodic contact with the client and the client's providers.

Termination of formal worker-client relationship – Worker and client acknowledge successful transition of care to other providers, celebrate the progress that's been made, express gratitude and grief in saying goodbye. Worker wishes the client well in the ongoing journey.

(Adapted from Outreach and Engagement CHECKLIST form,  
Northwest Resource Associates, Seattle, WA)



## He Sat Slumped on a Park Bench...

*(Approach)*

He sat slumped on a park bench, the rain pouring off him. His hands were grimy from days without washing. On his feet were broken shoes with no laces; all he wore was a light jacket on the cold November day. I went toward him a few steps. He took no notice. Quietly, I asked if it would be all right if I shared the bench. He said nothing. Tentatively I sat down with him in the rain.

Perhaps after ten minutes, I spoke again. "My name is Craig. I'm a Chaplain." A pause, then I asked, "Can I help?" Again, no response. From his demeanor, I guessed that the man might be experiencing a serious depression. I did not expect that it would be easy for him to speak. Minutes more went by. "It can be hard, very hard," I said. Once more, nothing. We sat together for almost half an hour. Slowly he lifted his head a little. "Nothing can be done," he said.

A bare thread, the merest, thinnest line between us. It took an hour or more to weave a few more such threads of conversation into enough of a connection that he was willing to go with me to a nearby drop-in center. There, over a cup of coffee, he was able to share a little of his story. He was homeless; he didn't know the shelters; he hardly ate any more; he didn't think anyone could help.

I invited him to go with me to the shelter. His hopelessness was overwhelming, almost totally paralyzing. He just shook his head. We waited. I was prepared to let things rest and try again the next day. What we did or did not do, how far we got that day was not nearly so important as how we treated each moment together. As it happened, we did go to the shelter. He was registered for the night, and I alerted the staff that he was new, and struggling. He had not wanted to talk with anyone else.

*(Towards Companionship)*

We visited again together over several days. He had been in the army and afterward managed a law office. While in that job, he became "very tired," listless. He started drinking and lost his position. He went into an alcohol treatment program and had been sober ever since. But again, the great tiredness came.

He had stopped going to his aftercare appointments and simply stayed in bed. His benefits were stopped, and he was evicted. He had been to treatment, but it hadn't helped; he didn't know what to do. I suggested that one of the staff at the shelter had some knowledge of this sort of thing, and we could possibly talk with him. I let the idea sit for a while.

*(Towards Partnership)*

The next week, with the man's agreement, a colleague from the mental health team joined us, just to get acquainted. The three of us met several times informally, in the shelter or on the street. It was awhile before the man was ready to go to the counselor's office. The visits continued, and slowly the possibility of depression was raised as something to look at.

A diagnosis can be hard to hear. Stigma, myth, fear of being crazy make it difficult to accept that this is something affecting our lives. A visit with a doctor was arranged, a time to ask questions and talk over what might be involved in care. Medications were explained and started. He applied for benefits again. A small apartment was arranged. Still, the man was doubtful. It was a month to six weeks before the medication took effect.

*(Towards Mutuality)*

Today, the man is an assistant manager of the building; he helps welcome and settle in others. He is a quiet and modest man, but very much part of our community, the man at the door.

(Outreach Encounter as told by Craig Rennebohm in Approach and  
Companionship in the Engagement Process)

# **1B: History and Philosophy of the Health Care for the Homeless Program**

## **Purpose**

To inform participants about how and why the Health Care for the Homeless program began and the underlying principles of the HCH approach to care

## **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 Video: "Health Care for the Homeless: *An Introduction*"**

Purpose: To provide an overview of the history and philosophy of the HCH program

Time: 30 min. (video is 20 minutes in length)

Materials:

TV/VCR

Copy of video "Health Care for the Homeless: *An Introduction*" (can be obtained from your local HCH program)

Preparation: View the video in advance to be familiar with its content.

Procedure:

1. Show the video "Health Care for the Homeless: *An Introduction*" which was produced by the Health Care for the Homeless Council, Inc. with a grant from the Bureau of Primary Health Care. The video is 20 minutes in length. It provides an excellent overview of the HCH program and its approach to care. Each HCH program has been provided with a free copy of the video along with a study guide.

2. After viewing the video, take time for questions and discussion. Use the accompanying study guide as a resource for discussion.

## **ACTIVITY 2 How the HCH Program Began**

Purpose: To help participants understand why and how the HCH program began and how it has evolved since that time.

Time: 10 minutes

Materials:

Web site: <http://www.nationalhomeless.org/facts.html> (The McKinney Act)

Web site: <http://www.bphc.hrsa.gov/homeless/> (Health Care for the Homeless Program)

Handout: How the HCH Program Began

Preparation:

Visit the web sites as noted and read the handout: "How the HCH Program Began" to become knowledgeable about the history of the program. You are also encouraged to learn about the history of your local HCH program and incorporate it into this learning activity.

Procedure:

1. Provide an overview of the HCH program history referring to the main points on the participant handout and other resource materials you read. Comment that initially it was hoped that the HCH program might serve as a stopgap measure while major steps to resolve homelessness were taken. Instead homelessness itself has become a "growth industry" and the HCH program has grown accordingly.
2. Describe the history of your local HCH program and how it fits in with the national HCH program.
3. Encourage those who want to learn more about the history of the HCH program to visit the web sites noted in the Materials section above.

# How the HCH Program Began

## A Brief History

### **1983** (Services began in 1985)

Nineteen demonstration projects in U.S. cities were privately funded by the Robert Wood Johnson Foundation, Pew Charitable Trusts and the U.S. Conference of Mayors to provide primary medical care and case management for homeless people with the purpose of:

- demonstrating new ways to deliver health and social services
- demonstrating better ways to link people with public benefits
- encouraging community agencies and organizations to work together to solve problems
- providing an opportunity for learning which may lead to further action
- making a difference for the homeless people served

### ***The Federal Response***

### **1987** (Services began in 1988)

- The Stewart B. McKinney Homeless Assistance Act provided additional funding for programs such as emergency food/shelter, transitional/long-term housing, health care, mental health services, education/job training
- Title VI of the McKinney Act created the HCH program under Section 340 within the Public Health Service Act (109 projects in 41 states)

### **1993**

- Bureau of Primary Health Care funded ten HCH projects to add outreach focusing on homeless children and their families

### **1996**

- Health Center Consolidation Act put the HCH program under Section 330(h) of the Public Health Service Act

### **2001**

- As of December 2001 there were 138 homeless health care projects in all 50 states, plus the District of Columbia and Puerto Rico

## **ACTIVITY 3 HCH 101 (Powerpoint Presentation)**

*This activity can be used as an alternative or a complement to Activities I and II.*

**Purpose:** To provide an overview of the history and philosophy of the HCH program

**Time:** 45 minutes

**Materials:**

LCD projector

HCH 101 Powerpoint slide presentation (downloaded from curriculum site)

Handouts of the slides for participants (optional)

**Preparation:**

Make printed copies of the slides (either 3 or 6 slides per page) as handouts for participants (optional).

Set up the LCD projector and download the HCH 101 Powerpoint presentation. Do a test run through the slides to ensure the equipment works and to familiarize yourself with the content. The material is written in outline form for succinctness. The presenter is expected to prepare additional remarks and relevant illustrations in order to elaborate on the material on the slides. In addition, be prepared to respond to questions participants might have.

The HCH 101 slide presentation covers the following topics in a condensed version:

- Realities of homelessness in the U.S.
- History of the HCH program
- Service delivery and sponsorship arrangements of HCH programs
- HCH approach to care
- Relationship of HCH programs to government and other funders
- Resources for HCH projects

Although some of these topics overlap with topics in other sections in Module I, the overall focus is primarily on the history and philosophy of the HCH program. It is recommended to use the slide presentation in its entirety. However, there may be circumstances where it's preferable to make use of selected slides only.

**Procedure:**

1. Make a presentation to participants about the history and philosophy of the HCH program using the slides to guide and prompt you. Be sure to provide additional information and illustrations; avoid simply reading the content on the slides.
2. Invite participants to raise questions and provide ample time for discussion.

# 1C: Outreach in the HCH Model

“To reach troubled souls  
you have to go where they are.”

## **Purpose**

To provide participants with an overview of outreach in the Health Care for the Homeless model of care

## **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.



## **ACTIVITY 1 Video: "Health Care for the Homeless: *Outreach*"**

*Activities 1 and 2 work best as companion activities. The handouts in Activity II expand upon the topics addressed in the outreach video shown in Activity I.*

Purpose: To highlight the vital role of outreach in providing health care services to homeless people

Time: 35 min. (video is 22 minutes in length)

Materials:  
TV/VCR

Videotape "Health Care for the Homeless: *Outreach*" (can be obtained from your local HCH program or ordered from the National Health Care for the Homeless Council)

Preparation:  
Preview the video to be familiar with its content and review the accompanying Study Guide.

Procedure:  
1. Show the video "Health Care for the Homeless: *Outreach*" produced by the Health Care for the Homeless Council, Inc. with a grant from the Bureau of Primary Health Care. The video is 22 minutes in length. It provides an excellent overview of the role of outreach in the HCH approach to care. Each HCH program has been provided with a free copy of the video along with a study guide.

2. After viewing the video, take time for questions and discussion. Use the Study Guide as a resource. Note that this discussion will likely move you naturally into Activity II below.

## **ACTIVITY 2    Who, What, Where, Why and How?**

*Activities 1 and 2 work best as companion activities. The handouts in Activity II expand upon the topics addressed in the outreach video shown in Activity I.*

Purpose: To highlight the main characteristics of outreach in the HCH approach to care

Time: 1 hour plus

Materials:

Resource Paper: Chapter on Outreach

Handouts:

- Purpose and Principles of HCH Outreach
- Outreach Mission Statement
- Where HCH Outreach Happens
- Services Provided Through HCH Outreach
- The Role of Outreach in the HCH Project
- Obstacles HCH Projects Face in Doing Outreach
- Professional and Personal Characteristics of HCH Outreach Workers
- Cross-Disciplinary Team Approaches
- Outfitter's Guide for HCH Outreach Workers

Preparation:

Review the content of each of the handouts. Also read the resource paper, a chapter on outreach from Organizing Health Services for Homeless People by Marsha McMurray-Avila.

Consider how best to present the material in these handouts. You may wish to present all of the material yourself allowing for ample time to respond to questions. However, if it seems appropriate, it is recommended you follow the procedure outlined below to create a livelier learning situation.

Procedure:

1. Ensure participants have access to the handouts listed above. Assign each handout to a participant. If there are more handouts than people, then assign additional handouts to each individual. Conversely, if there are more people than handouts, form small groups per handout.

2. Instruct everyone in the group to study their handout(s) for a short period of time. Then, in the order as listed above, have them provide a short presentation to the whole group on the content of the handout. Encourage presenters to use illustrations and to be imaginative in how they present their material so as to engage their audience.

3. As the facilitator, be prepared to augment the presentations with additional information and insights from your own outreach experience.

# **Outreach**

## **Introduction**

The public health principles underlying the HCH philosophy are nowhere more evident than in the program's strong emphasis on outreach. As a means to improving the health of a community by taking services, health education and disease prevention to the most underserved, outreach has historic precedents going back to the 18<sup>th</sup> and 19<sup>th</sup> centuries in the urban slums of Europe and the United States.<sup>2</sup> Since that time public health practice has been committed to moving health services beyond the walls of traditional medical institutions, out into the community. That commitment is reflected today in HCH projects across the country, as they reach out to homeless people on the streets, under bridges, in shelters, soup kitchens, drop-in centers and wherever those most underserved are likely to be found.

HCH outreach is aimed at breaking down the psychological and systemic barriers to care faced by homeless people, which have been discussed in previous chapters. Activities designed to overcome those barriers range from establishing rapport for purposes of engaging people in services later, to disseminating information on services available from HCH or other agencies, to directly providing an array of medical, mental health and social services.

Although outreach is required of federally-funded HCH projects, the actual services provided as part of outreach vary greatly according to the needs in a particular community. This chapter will cover the essential elements of outreach, as answered by the following questions:

- **What elements/principles define outreach in the HCH context?**
- **Where does outreach happen and how?**
- **What services can be provided through outreach?**
- **What role does outreach play in an HCH project?**
- **What obstacles do HCH projects face in doing outreach?**
- **Who should provide outreach services?**

### **What elements/principles define outreach in the HCH context?**

The term "outreach" can mean many things and encompasses a broad range of potential activities. To avoid "hinging the definition of outreach on any specific service activity," Morse<sup>3</sup> has suggested giving outreach a "process definition." Although his definition is specifically directed toward mental health outreach, it could easily apply to any HCH outreach activity in that it is "contact with any individual who would otherwise be ignored (or unserved)...in non-traditional settings for the purposes of improving their

mental health, health, or social functioning or increasing their human service and resource utilization.”

In some contexts, outreach may refer to interaction with other service provider organizations to inform them of HCH services and referral policies, or to do consultation or health education with the agency staff. This chapter, however, focuses on outreach in relation to an individual who is homeless. The first and most central element of HCH outreach is the goal of reaching homeless people who would otherwise not receive services.

Some people who are homeless are not engaged in services because they are unaware of what is available, either due to the complexity of the service system or being new to the area. For a variety of reasons, other people who are homeless actively avoid services of any kind. They may suffer from mental disorders that cause paranoia or lack of insight into their need for care. They may be substance abusers who cannot stay in shelters if they are drinking or using drugs, so they stay on the streets. They may be veterans suffering from post-traumatic stress syndrome, wary of the system. They may be women fleeing domestic violence, afraid to go to service sites for fear of encountering their batterer. They may be runaway or throwaway youth, convinced of their own immortality and suspicious of any agency trying to help them. Or they may simply be people who have had negative experiences with institutions in the past.

Schutt and Garrett comment that

*In spite of these understandable reasons for rejecting services, research indicates that many homeless persons respond positively to offers of help that are made in an appropriate manner... The key is to provide help with the most immediate needs first – sandwiches for those living on the streets, showers, clean facilities, a pleasant environment, and physical health care for those staying in shelters – before attempting to address problems in social relations, psychiatric difficulties or substance abuse. Persistence and a gradual approach can pay off in the long run.<sup>4</sup>*

*“(E)ven the most initially resistant and chronic substance abusers can be cajoled into accepting services if they are offered in an appropriate manner. Outreach workers must be sympathetic and non-judgmental, but at the same time, aggressive and persistent. Outreach efforts must be conducted on the client’s turf and be able to meet basic, immediate needs such as food and clothing. Ongoing contact over long periods of time is often necessary in order to develop the level of trust which is critical to engaging some homeless clients – many of whom are wary of service systems which have failed to work for them, or which have treated them badly, in the past.”<sup>5</sup>*

Lydia Williams

*Addiction on the Streets: Substance Abuse and Homelessness in America*  
National Coalition for the Homeless

While some HCH projects do outreach to the general population of people who are homeless, others reach out to vulnerable subgroups, such as people with mental disorders, substance abusers, people at risk for contracting HIV/AIDS, families with children, or runaway and throwaway youth. Many projects use a combination of both general and specialized outreach with different staff responsible for certain subgroups or locations.

Whoever the target for outreach is, no matter what services are provided or where, certain principles describe what makes outreach successful:<sup>6 7</sup>

- A non-threatening approach
- Flexibility in the menu of services offered and the manner in which they are provided
- Repeated contact over extended periods of time, achieved by bringing services to clients rather than waiting for them to come to the services (“response to need rather than demand alone”<sup>8</sup>)
- Allowing for flexible and varied times for client contact, including non-scheduled contacts
- Responding quickly to an individual’s perceived needs for food, money, and housing
- Conducting an assessment of the individual’s comprehensive, holistic needs, and then tailoring services and strategies to meet those unique needs and characteristics
- Providing engagement services for clients who are reluctant or suspicious to receive help
- Patience in motivating clients to accept treatment and services
- Using a team approach to outreach

Regarding the element of patience and the amount of time it may take to actually engage clients in services, outreach staff who work with people who are homeless and have serious mental illness have reported that it can take about nine months to engage their clients into basic services, such as food, shelter, and health care programs; another three to six months to convince them of the value of obtaining benefits and taking medication; and another nine to 12 months to obtain permanent housing, with ongoing case management support.<sup>9</sup> Such time frames will vary widely – from days to years just to establish rapport – depending on the individual and the circumstances.

## **Where does outreach happen and how?**

The “non-traditional” settings referred to in the definition above can generally be divided into two categories: fixed site and mobile. **Fixed-site outreach** includes the common HCH practice of establishing clinics in or near shelters, soup kitchens or other service facilities. Basically, HCH staff are “setting up shop” in a location where people who are homeless already gather. Fixed-site outreach could also include operating a drop-in center that offers a safe place to spend time, protected from the elements and the

violence of the streets, as well as a place to receive other services such as showers, clothing, food or laundry facilities.

*“Drop-in centers, which are generally small, accessible, store-front locations, are often effective in engaging portions of the homeless mentally ill population that are typically not reached by other service interventions.<sup>10</sup> Distinguished from more formal programs by their casual accessibility, these centers can offer a place to sit during the day, a place to sleep at night, or both. They are particularly inviting to many homeless mentally ill individuals because they ask few questions and make no demands. Like other outreach efforts, they often become a bridge to the more formal service delivery and/or shelter network.”<sup>11</sup>*

Federal Task Force on Homelessness and Severe Mental Illness  
*Outcasts on Main Street*

**Mobile outreach** moves around and can happen anywhere people who are homeless might be found. Options for carrying out mobile outreach include: mobile units (sometimes fully equipped as clinics – see chapter on “Strategies to Enhance Access”); vans or other vehicles; or on foot. Some outreach teams have set “routes” that they follow on specific days. Others may be more flexible, responding to the needs that particular day or searching out certain people they need to contact.

Common street locations for outreach are under bridges and freeway overpasses, alleys, parks and vacant lots. In rural areas or on the fringes of urban areas, outreach workers may go to the riverbanks, foothills, wooded areas or desert. Mobile outreach can also frequent public facilities where people without homes may take shelter during the day, such as libraries or transportation terminals. Many outreach teams go to welfare hotels, cheap motels or SRO’s where people live on the edge of homelessness. Some teams have special arrangements with jails, detox/treatment programs or other institutions to enter and make contact with ongoing HCH clients or potential clients regarding available services when they are released. And, of course, teams will often visit shelters, soup kitchens and other service locations.

Many HCH projects use a combination of both approaches to outreach, for example, operating a fixed-site clinic next door to a shelter, while sending teams out into the streets on a regular basis. This combination is particularly helpful in that the two approaches complement each other. Many times people are encountered during outreach who need more complex care than what can be provided on the street, in a shelter, or even in a mobile unit. They can then be referred to the fixed-site location which is usually better-equipped. Conversely, staff in fixed-site locations may depend on outreach workers to find clients who need follow-up.

## **What services are provided through outreach?**

The menu of services that can be provided during outreach is limited only by imagination and resources. The continuum of options could be divided into three general activities: (1) engagement strategies; (2) information and referral; and (3) direct services. The first two are more likely to happen on mobile outreach or at an HCH-affiliated drop-in center, while direct services could be provided during mobile outreach, at a drop-in center or at a fixed-site.

### Engagement strategies

- Initiating non-threatening conversation
- Offering sandwiches and coffee or other food and beverage
- Offering blankets, sleeping bags, socks, hats, etc.
- Offering hygiene articles, sunscreen, condoms, etc.

### Information and referral

- Offering information about available services from HCH or other agencies, including shelters, “safe havens” and other housing options as a transitional step between engagement and providing direct services

### Direct services

- Providing medical care, mental health or substance abuse services directly
- Offering formal referrals for specialty care, dental care, mental health services, substance abuse treatment or other services not available from HCH
- Assessing a client’s medical, psychiatric and social needs and developing a treatment plan
- Providing social service assistance (referrals to housing or shelter, accessing entitlements, replacing identification, etc.)
- Providing case management
- Counseling
- Facilitating support groups, life-skills training
- Health education/promotion
- Crisis intervention, such as links to emergency medical or psychiatric care
- Screening for specific diseases or disorders
- Advocating with other agencies for client to receive necessary services
- Other services that may be linked to the site, including food, clothing, showers, laundry, etc.



*“Street outreach must include the capacity for an emergency response as well as engagement. Homeless mentally ill individuals often are found living in life-threatening circumstances and/or in precarious locations....some homeless mentally ill individuals living on the streets are unable or unwilling to go indoors in below-freezing temperatures. For reasons such as these, crisis outreach teams need to be available to evaluate individuals and transport them, if necessary to emergency or inpatient services. Backup medical and psychiatric support is essential to ensure access to involuntary treatment when it is needed.”<sup>12</sup>*

Federal Task Force on Homelessness and Severe Mental Illness  
*Outcasts on Main Street*

HCH projects pull from this menu of possible services to design an outreach program in response to the specific needs and characteristics of people who are homeless in their community. Some outreach teams may be trained and professionally skilled to respond at any level. For example, a team that includes a medical provider and/or a social worker could either provide direct services, triage for referrals, or limit their encounter to engagement strategies with those clients who are reluctant to accept services. Other outreach teams may only be qualified to engage clients and provide information on services, with referrals for direct services made to HCH sites or other agencies.

HCH staff who do outreach also need to be aware of other organizations involved in outreach work, so that efforts can be coordinated when possible. For example, some public health departments may do outreach focused on screening for HIV or TB. Some shelters or missions do outreach on cold nights to help people find shelter. HCH outreach workers may want to collaborate with other outreach programs on a regular basis to enhance the effectiveness of their efforts.

### **What role does outreach play in an HCH project?**

Outreach is the entryway to services and safety that otherwise might not be available for some homeless people. It serves as the crucial link between the streets and HCH services. Although HCH outreach workers may have contact on the streets with homeless people who do not need or never make use of HCH services, they are especially effective when they can identify and engage those people who need the services HCH has to offer. Outreach workers of any professional discipline should represent the compassion and respect that people who are homeless will find when receiving other HCH services.

As the first contact with an individual who is homeless, outreach workers can ease the way into a trusting relationship with other HCH providers.

In addition to the assistance they provide to people who are homeless, outreach workers are also valuable to the HCH organization for:

- Providing follow-up on HCH clients, such as locating medical clients who need to be informed of lab results, or monitoring the progress or behavior of a case manager's client on the streets
- Assessing ongoing needs of people who are homeless, including changes in demographics such as increases in families or youth or particular cultural groups (useful for reports and funding proposals)
- Keeping HCH staff informed of health issues on the streets, including trends in drug-use or violence
- Serving as a HCH representative to other service agencies or public entities, including police officers and corrections facilities
- Guiding other HCH staff who normally work in clinical or administrative settings through outreach locations to keep them in touch with the realities of their clients' living situations

*"The mobile outreach team in Milwaukee was among the first to be fully developed and to be studied carefully. The team uses a mobile van which daily tours the shelters, meal sites, and other congregating areas around the inner city. Its members are chosen for attributes that lessen social distance from clients, and they use strategies of relationship building and power sharing designed to create trust. Team members function as case finders, case managers, and advocates, dealing with multiple problems, meeting basic needs, and providing linkages between the clients and disparate parts of the human resource system. Its members maintain sustained contact with clients placed in various outreach programs (such as the correctional services homeless program) and often organize and engage in social activities with their clients, such as movies, bowling, picnics, and shopping." <sup>13</sup>*

Barry Blackwell, MD, et al.

"Psychiatric and Mental Health Services"

*Under the Safety Net: The Health and Social Welfare of the Homeless in the U.S.*

Some outreach programs have begun to take an even more active role in the case management of clients they encounter. For example, since the Milwaukee outreach team was first initiated, the function of outreach workers has been expanded to include coordination of services within a continuum of care. Each team member maintains a minimum case load of 10 individuals for whom they function as the primary case manager, linking them to services and making sure they stay linked for as long as necessary to get them stabilized in transitional or permanent housing.<sup>14</sup>

## **What obstacles do HCH projects face in doing outreach?**

One of the biggest obstacles to effective outreach work is the scarcity of resources to which people who are homeless can be referred once they are ready and willing to accept services. Williams discusses the effects of a shortage of substance abuse services in the community, based on a National Coalition for the Homeless survey:

*Outreach efforts are only as successful as the outreach worker's ability to offer immediate access to the services desired by the client. However, backlogs in the treatment system are disrupting efforts by the programs we surveyed. Providers reported enormous frustration among outreach workers who, after months of contact, are unable to deliver on promised services once the client is ready to accept them.<sup>15</sup>*

The shortage of services may also be a reflection of lack of capacity in the HCH project. For example, a common lament of HCH case managers is that their case loads are "maxed out" and yet the outreach workers keep finding more and more people who need their services. The same is true of HCH treatment programs or transitional housing with limited capacity.

Another issue related to lack of capacity within the HCH project occurs when a project becomes well-established in a fixed location, such as a clinic, and has a strong enough reputation through word-of-mouth that the waiting room is always full. Providers may then have difficulties breaking away to do outreach. They are faced with either staying in the clinic site to serve those in need who have the desire and ability to seek out services, or doing outreach to serve those in need who have neither that ability nor desire. Outreach workers who are not medical providers or mental health workers may report that those staff are desperately needed on the outreach team, but there are simply not enough staff members to go around.

The obvious solution to the lack-of-capacity dilemma is to increase the number of staff, but that is not usually possible due to funding limitations. Instead, it often becomes necessary for the project to prioritize where they put their time and resources. Are the resources better used by serving more people who have relatively fewer needs or fewer people with more complex problems? It is hoped that, with sufficient information about their community's population of people who are homeless, and with healthy dialogue among staff, Board and consumers, a workable balance can be found between these two targets. Whatever decision is reached, outreach workers need a clear understanding of their role, both in relation to the people they encounter on outreach and to their HCH colleagues.

Another obstacle in outreach work is the frustration of spending time looking for someone who can't be found, or spending months trying to engage someone, only to have them disappear, or worse yet, die. Patience and persistence often pay off, but not always. Staff involved in outreach need to share this frustration and to regain perspective by focusing on the incremental successes, using their supervisory and team relationships for support.

Outreach workers also may encounter resistance in the community stemming from anti-homeless sentiments. A common trigger for community antagonism is panhandling or signing, especially when it appears to be linked to substance abuse. Outreach workers may have to make a special effort to educate police, business people and neighbors about homelessness to gain their support and cooperation in areas where panhandling is seen as a hindrance to business or tourism.

The danger inherent in outreach work is another obstacle. Outreach teams have no guarantee when going into an unknown camp, vacant building or dark alleyway that the people they encounter will be glad to see them. Whether human beings are housed or homeless, there will always be those who are involved in illicit activity, who are running from the law, or who are violent. It is essential for anyone doing outreach to stay centered, cautious and alert at all times. An outreach worker on the street alone runs a significant risk. Outreach should be done in teams of at least two people, making sure other staff know their location and keeping a cellular phone handy. Training in self-defense and de-escalation of potentially violent situations should be provided to all staff involved in outreach work.

### **Who should provide outreach services?**

Projects may have staff who only do outreach, or they may have staff who normally work in fixed-sites accompany the outreach team either on a regularly scheduled basis or occasionally as time permits. And as indicated by the long list of potential services that can be provided through outreach, the staff involved can vary significantly – from medical providers and doctorate level professionals to masters or bachelors level counselors, social workers or case managers to paraprofessionals without degrees, including peers or consumers. People who do outreach need to meet the professional criteria for whatever level of services they are providing, as well as the personal characteristics necessary to do good outreach work. Of course, all staff or volunteers involved in outreach – whether trained professionally or not – need a solid understanding of mental illness, substance abuse, community resources available and the ethics of providing services.

Most of the desired personal characteristics for staff who do outreach can be derived from the discussions above regarding what makes outreach effective. Although it could easily be said that these are the characteristics needed for anyone working with

clients in an HCH project, the need for outreach workers to embody these characteristics is heightened by the settings in which they work. Staff doing outreach should be:

- flexible – able to change directions (literally or figuratively) at a moment’s notice
- non-judgmental – willing to let clients define their own needs, without jumping to conclusions or diagnoses
- relaxed – easy to talk to and able to easily initiate conversation in a non-threatening manner
- patient
- respectful
- diplomatic and tactful – able to negotiate acquisition of services for clients without alienating other service providers and able to convince law enforcement that they are allies while still defending the rights of the clients
- resourceful and creative – both in finding ways to engage clients, as well as finding the resources they need
- centered – with a strong self-concept and clear boundaries, especially in terms of staff-client interactions
- calm and clear-headed in emergency situations
- assertive, but cautious and alert to possible danger
- able to communicate clearly and directly with clients, fellow staff or other agencies
- independent and able to take initiative, while also being a strong team player

*“Anyone who works with homeless persons, whether providing clothing or mental health services, requires a particular blend of personal and professional characteristics. The clients served are a low-status, non-prestige group who often are stigmatized and feared by the general population. Outreach workers may experience a sense of non-affiliation, especially when they work in a variety of host agencies. At times one must function autonomously; at other times one must shift rapidly from working with homeless persons to working with social service bureaucrats or highly placed community officials. This situation challenges the workers’ adaptability and flexibility.”<sup>16</sup>*

J.Thomas Ungerleider, et al.  
“Mental Health and Homelessness: The Clinician’s View”  
*Homelessness: A National Perspective*

## Notes

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- <sup>1</sup> Case study from Philadelphia HCH. 1997.
- <sup>2</sup> E.B.G. Hebenstreit. Principles of the Science of Medical Police. In G. Rosen (Ed.), *From Medical Police to Social Medicine: Essays on the History of Health Care*. New York: Science History Publications, 1974, pp. 176-200.
- <sup>3</sup> G. Morse. *Conceptual Overview of Mobile Outreach for Persons Who Are Homeless and Mentally Ill* presented at the American Public Health Association in New Orleans, Louisiana, October 1987, p. 9.
- <sup>4</sup> R.K. Schutt and G.R. Garrett. Counseling and Case Management. In R.K. Schutt and G.R. Garrett (Eds.), *Responding to the Homeless: Policy and Practice*. New York: Plenum Press, 1992, pp. 46-47.
- <sup>5</sup> L. Williams. *Addiction on the Streets: Substance Abuse and Homelessness in America*. Washington, DC: National Coalition for the Homeless, 1992, p. 25.
- <sup>6</sup> D. Oakley and D.L. Dennis. Responding to the Needs of Homeless People with Alcohol, Drug, and/or Mental Disorders. In J. Baumohl (Ed.), *Homelessness in America*. Phoenix: Oryx Press, 1996, p. 182.
- <sup>7</sup> G. Morse. 1987, p. 10.
- <sup>8</sup> S.L. Wobido, et al. Outreach. In P.W. Brickner (Ed.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, p. 329.
- <sup>9</sup> L.M. Reyes. *Local Responses to the Needs of Homeless Mentally Ill Persons*. Washington, DC: U.S. Conference of Mayors, 1987.
- <sup>10</sup> I.S. Levine. Service Programs for the Homeless Mentally Ill. In H.R. Lamb (Ed.), *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association*. Washington, DC: American Psychiatric Association, 1984.
- <sup>11</sup> Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street*. Washington, DC: Center for Mental Health Services, 1992, p. 37.
- <sup>12</sup> Federal Task Force on Homelessness and Severe Mental Illness. 1992, pp. 36-37.
- <sup>13</sup> B. Blackwell et al. Psychiatric and Mental Health Services. In P.W. Brickner (Ed.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, p. 190.
- <sup>14</sup> Memo from Alice Fletcher, Director of Programs. HCH of Milwaukee, 1997.
- <sup>15</sup> L. Williams. 1992, p. 25.
- <sup>16</sup> J.T. Ungerleider, et al. Mental Health and Homelessness: The Clinician's View. In M.J. Robertson and M. Greenblatt (Eds.), *Homelessness: A National Perspective*, New York: Plenum Press, 1992, p. 112.

(This chapter on Outreach taken from *Organizing Health Services for Homeless People: A Practical Guide* by Marsha McMurray-Avila)

# Purpose and Principles of HCH Outreach

## Purpose

*“...contact with any individual who would otherwise be ignored (or underserved) ...in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.”*

(Morse, (1987) Conceptual overview of mobile outreach for persons who are homeless and mentally ill, presented at the APHA in New Orleans, LA)

## Principles

- Friendly, non-threatening approach
- Services taken to individuals rather than waiting for them to come to the services
- Repeated contact over time
- Engagement of those who are reluctant or suspicious to receive help
- Prompt response to client's basic survival needs
- Client's overall needs assessed, services and strategies tailored to meet those unique needs
- Flexibility in the menu of services offered
- Patience in motivating clients to accept services
- Variable times for client contact, including non-scheduled contacts
- Team approach to outreach

(Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997)

Sample Mission Statement

**OUTREACH**

To locate and inform homeless people of the availability of health care and social services

To identify and reduce barriers to care and increase service utilization

To integrate primary care with substance abuse treatment and mental health treatment on behalf of recipients

To provide team-oriented case management

To establish and maintain collaborative linkages with other programs serving the homeless population

- Phoenix, AZ HCH Program



# Where HCH Outreach Happens

The “non-traditional” settings to which outreach teams go can be divided into two categories: fixed site and mobile. **Fixed site outreach** occurs in places where HCH programs have “set up shop” in a location where people who are homeless already gather. **Mobile outreach** moves around and can happen anywhere people who are homeless might be found.

Options for carrying out mobile outreach include: mobile medical units, vans or other motor vehicles, bicycles or on foot. In Pittsburgh, outreach workers paddle kayaks to reach people living along the riverbanks.

Some outreach teams have set “routes” that they follow on specific days. Others may be more flexible, responding to the needs that particular day or searching out certain people they need to contact.

Examples of each are listed below.

## Fixed-site

Scheduled clinics in or near:

- shelters, missions
- drop-in centers
- transitional housing
- respite programs
- soup kitchens
- hygiene facilities
- other homeless facilities

## Mobile

Street locations:

- city streets, alleys
- bridges and overpasses
- subways
- parks, beaches
- vacant lots, abandoned buildings
- vehicles

Rural areas:

- “doubled up”
- along roads, vehicles
- wooded areas, riverbanks
- foothills, desert areas
- barns, garages
- camps (e.g. of agribusiness workers)

**Public facilities:**

- libraries
- bus or train stations
- airports
- racetracks
- cafeterias, coffeeshops

**Institutions (to make contact with ongoing HCH clients or potential clients):**

- hospitals
- jails, prisons
- detox facilities, treatment programs
- some hotels/motels/SRO's
- public welfare agencies

Many HCH projects use a combination of both approaches to outreach, for example, operating a fixed-site clinic next door to a shelter, while sending teams out into the streets on a regular basis. This combination is particularly helpful in that the two approaches complement each other. Many times people are encountered during outreach who need more complex care than what can be provided on the street, in a shelter, or even in a mobile unit. They can then be referred to the fixed-site location which is usually better equipped. Conversely, staff in fixed-site locations may depend on outreach workers to find clients who need follow-up.

(Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997)

# Services Provided Through HCH Outreach

## ***Engagement strategies***

- Create a safe “presence” – make non-verbal contact
- Initiate non-threatening conversation
- Offer sandwiches and coffee
- Offer a blanket, sleeping bag, hat, socks
- Offer sunscreen, condoms, hygiene articles

## ***Information and referral***

- Provide information about available services from HCH or other agencies

## ***Direct services***

- Assist with accessing shelter/housing, entitlements, ID, legal assistance
- Assist client in utilizing services linked to particular site – food, clothing, showers, laundry, phone, mail, etc.
- Assess a client’s medical, psychiatric and social needs and develop a treatment plan
- Provide direct medical care, mental health or chemical dependency services
- Screen for specific diseases or disorders
- Make referrals to specialty care, dental care, mental health services, chemical dependency treatment, or other services not available from HCH
- Provide case management
- Advocate with other agencies for client to receive necessary services
- Give support and counsel
- Facilitate support groups, life-skills training
- Provide health education/promotion
- Intervene in crisis situations making links to emergency medical or psychiatric care

(Adapted from Marsha McMurray-Avila in Organizing Health Care Service for Homeless People, 1997)

# The Role of Outreach in the HCH Project

Homeless people, especially those experiencing serious disabling conditions and/or long-term homelessness, often have difficulty finding or accepting the services and care they need. This may be related to fear, lack of awareness, ambivalence, loss of hope, or any other number of personal reasons. Too often, services are difficult to access because of significant barriers presented by the system itself.

Stepping into this divide are HCH outreach workers who attempt to mediate and overcome these psychological, informational, and systemic barriers to care. Outreach workers offer an entryway to services and safety, providing a vital bridge between the streets and a more stable life.

In addition to the outreach, engagement and direct assistance they provide to people who are homeless, outreach workers are also valuable to the HCH organization to:

- ✓ Provide follow-up on HCH clients, such as locating medical clients who need to be informed of lab results, or monitoring the mental health status of a client on the streets
- ✓ Assess ongoing needs of the homeless population, including changes in demographics such as increases in families or youth or particular cultural groups (useful for reports and funding proposals)
- ✓ Keep HCH staff informed of health issues on the streets, including trends in drug-use or violence
- ✓ Serve as an HCH representative to other service agencies or public entities, including police officers and corrections facilities
- ✓ Guide other HCH staff who work in clinical or administrative settings through outreach locations to keep them in touch with the realities of their clients' living situations

(Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997)

## **Obstacles HCH Projects Face In Doing Outreach**

- Scarcity of resources in the community to which people who are homeless can be referred
- Lack of capacity within the HCH project to provide care for all who need it
- Difficulty breaking away to do outreach to those who are not seeking services when the shelter clinic is filled with those waiting to receive care
- Dilemma of fund allocation -- using resources to serve more people who have relatively fewer needs or fewer people with more complex problems
- Frustration and "inefficiency" of spending time looking for someone who can't be found, or spending months trying to engage someone, only to have them disappear, or worse yet, die
- Resistance in the community stemming from anti-homeless sentiments
- Inherent danger in doing outreach work – not knowing what the outreach team will encounter when going into an unknown camp, vacant building or alleyway

(Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997)

# Professional and Personal Characteristics of HCH Outreach Workers

## Professional Characteristics:

Given the range of services that can be provided through outreach, the staff involved can vary significantly – from *medical providers and doctorate level professionals to masters or bachelors level counselors, social workers or case managers to paraprofessionals without degrees, including peers or consumers.*

## Personal Characteristics:

Effective HCH outreach workers are able to be:

- flexible – able to change directions (literally or figuratively) at a moment's notice
- non-judgmental – willing to let clients define their own needs, without jumping to conclusions
- respectful
- relaxed – easy to talk with and able to initiate conversation in a non-threatening manner
- tactful – able to help clients acquire services without alienating other service providers and able to convince law enforcement that they are allies while still defending the rights of the clients
- patient
- resourceful – find creative ways to engage clients and meet their needs
- centered – with a healthy sense of self and clear boundaries
- calm and clear-headed in emergency situations
- assertive
- cautious and alert to possible danger
- independent and able to take initiative, while being strong team players

(Adapted from Marsha McMurray-Avila in Organizing Health Care Services for Homeless People, 1997)

# **Cross-Disciplinary Team Approaches**

## ***Multidisciplinary***

- Team members work parallel to each other to address common problems
- Results usually brought together at the end
- Working together in this fashion doesn't ensure disciplines actually work together

## ***Interdisciplinary***

- Team works jointly but still from discipline-specific perspectives
- New insights to address problems result from shared staff conferencing
- Improvement over the multidisciplinary approach

## ***Transdisciplinary***

- Teams work jointly to address common problems by using a shared conceptual framework drawing from discipline-specific theories, concepts and approaches
- Transcends separate disciplinary approaches
- "Outside the box" thinking
- Whole person orientation

*Adapted from Patricia L. Rosenfield: Potential of Transdisciplinary Research,  
Social Science Medicine. Vol. 35, No. 11, pp. 1343-1357, 1992*

# **Outfitter's Guide for HCH Outreach Workers**

How to Dress for Success as an Outreach Worker!

## *High Recommended*

- Casual, comfortable clothing appropriate to the weather – wear layers as needed -- avoid excessive jewelry, expensive watches, anything that creates “social distance”
- Shoes that fit well, provide good support, are sturdy and comfortable
- Cell phones and/or pagers, preferably for each worker, for communication and safety purposes
- Resource directory and informational handouts for relevant services

## *Suggested*

- Backpack/knapsack
- Provisions to give out (food, coffee in a thermos, hygiene kits, gloves, socks, hats, coats, blankets, etc.)
- Map, flashlight, pen and paper
- First aid kit, water
- Non-water-dependent disinfectant gel hand soap (for use in private)
- Supplies for medical outreach workers

(Adapted from outline for workshop “Outreach and engagement with persons who are homeless and mentally ill” presented at 2000 National HCH Conference by Vance Baker, MD, John Goren, and David Mitchell)



## **ACTIVITY 3 HCH 101 (Powerpoint Presentation)**

*This activity can be used as an alternative or a complement to Activities 1 and 2.*

Purpose: To provide an overview of the history and philosophy of the HCH program

Time: 45 minutes

Materials:

LCD projector

HCH 101 Powerpoint slide presentation (downloaded from curriculum site)

Handouts of the slides for participants (optional)

Preparation:

Make printed copies of the slides (either 3 or 6 slides per page) as handouts for participants (optional).

Set up the LCD projector and download the HCH 101 Powerpoint presentation. Do a test run through the slides to ensure the equipment works and to familiarize yourself with the content. The material is written in outline form for succinctness. The presenter is expected to prepare additional remarks and relevant illustrations in order to elaborate on the material on the slides. In addition, be prepared to respond to questions participants might have.

The HCH 101 slide presentation covers the following topics in a condensed version:

- Realities of homelessness in the U.S.
- History of the HCH program
- Service delivery and sponsorship arrangements of HCH programs
- HCH approach to care
- Relationship of HCH programs to government and other funders
- Resources for HCH projects

Although some of these topics overlap with topics in other sections in Module I, the overall focus is primarily on the history and philosophy of the HCH program. It is recommended to use the slide presentation in its entirety. However, there may be circumstances where it's preferable to make use of selected slides only.

Procedure:

1. Make a presentation to participants about the history and philosophy of the HCH program using the slides to guide and prompt you. Be sure to provide additional information and illustrations; avoid simply reading the content on the slides.
2. Invite participants to raise questions and provide ample time for discussion.

# 1D: The Realities and Experience of Homelessness

"At varying levels of analysis, homelessness is a housing problem, an employment problem, a demographic problem, a problem of social disaffiliation, a mental health problem, a substance abuse problem, a family violence problem, a problem created by cutbacks in social welfare spending, a problem resulting from the decay of the traditional nuclear family, and a problem intimately connected to the recent increase in persons living below the poverty level, as well as others."

*James Wright in "The Worthy and Unworthy Homeless," Society, July/August 1988*

Homeless people are "the sum total of our dreams, policies, intentions, errors, omissions, cruelties, and kindnesses" as a society.

*Peter Marin, sociologist*

"Homelessness is hell."

*Ed Loring, minister*

## Purpose

The purpose of this section is to become more knowledgeable about the causes and conditions of homelessness and to develop increased empathy for those who endure it.

## Recommendations for Instructors

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 A Conversation with Guests who Have Experienced Homelessness**

Purpose: To learn about the realities of homelessness from those who have experienced it first-hand

Time: 1 hour

Materials: A suitable room and refreshments

### Preparation:

Invite one or two guests who have experienced homelessness to meet with the group to talk about various aspects of their experience, including what counsel they might have for outreach workers. If your outreach is targeted to a specific population, then invite guests from within that group. Having more than one guest will provide a broader perspective for participants. It may also make it more comfortable for your guests.

Encourage an informal conversational approach in a setting that is suitable especially for the presenters. For example, choose a setting perhaps outside of your agency that is casual, relaxed and comfortable for everyone. It needs to afford sufficient privacy.

Beforehand, have the group think about what it is they'd most like to learn from such an interchange, specifically related to gaining a better understanding of the realities of homelessness and how one might be more effective in providing outreach services.

Consider offering some form of compensation to guests for their consultation. This may be in monetary or some other form of payment. It is recommended that you discuss this with the guest presenter ahead of time.

### Procedure:

1. Introduce the guest(s) and restate why you've requested they come to share their experience.
2. Facilitate the meeting in a manner that ensures a sense of comfort and safety for all, especially the presenter(s).
3. Thank the guest(s) for their time and participation in training others to do the work of outreach.

## ACTIVITY 2 “A Resident of Nowhere”

Purpose: To increase understanding and empathy by exploring “a day in the life” of a homeless man

Time: 30 minutes

Materials:

Handout: “A Resident of Nowhere”

Flipchart and markers

Preparation:

Read the handout in advance to familiarize yourself with the story. Take some time to reflect on it and what it brings up for you. Prepare for the guided discussion with the group by reading the procedure steps below.

Procedure:

1. Request one or more people to read aloud to the group the story of Henry in “A Resident of Nowhere.” Encourage participants to try to “walk a mile in Henry’s shoes” in this exercise as a way to develop increased empathy.
2. Facilitate a discussion upon completion of the reading. Initially ask for general comments and impressions, e.g., “What struck you most about Henry’s experience? Was there anything that took you a bit by surprise? What emotions came up for you as you listened?”
3. On a flipchart list the headings *Physical – Psychological – Social – Existential*. Leave enough space under each to write a number of examples. Based on the reading, ask the group to identify various dimensions of Henry’s experience of homelessness by lifting out words, phrases and ideas from the story.
4. Write these comments down on the flipchart under the heading that seems to fit best and have the group discuss and elaborate as needed. Try to convey in this exercise the multi-dimensional impact of homelessness on people’s lives, that homelessness affects one’s whole being. Thus, we need to respond at these various levels.

Below are examples from Henry’s story that might be noted and discussed.

*Physical*

- “sleep comes in only bits and pieces, so he is exhausted”
- “pulls his aching body out of the chair”
- “hunger hurts”
- “now he stinks”

*Psychological*

"a flicker of desire passes through the broken man's heart"  
"torn between another day of hunger and a \$25 paycheck"  
"nothing to do but wait"

*Social*

"for there is no one with whom to share this most human wish"  
"an enemy of the professional, a discarded person, a bum"

*Existential*

"homelessness is absurd"  
"a resident of nowhere"  
"Henry's day that really never began"  
"here bleeding, Henry is safe"

# A Resident of Nowhere

*By Ed Loring*

Homelessness is absurd. Homelessness is unnecessary. Homelessness is hell. Homelessness is dereliction, frostbitten toes, crooked and lost fingers, burning, bleary eyes with bad vision and a pair of drugstore reading glasses to mask the shame and blindness.

Homelessness is Henry. Henry grew up in North Carolina and 20 years ago came to Atlanta in search of work and his shot at the American Dream. Black, strong, easygoing, Henry now finds himself a resident of nowhere, while a member of the human community that names itself Atlanta. Henry lost job after job as do all unskilled workers in our economy. Henry drinks alcohol to ease his pain and grasp once more at his dream, in the same way others do at a Falcons football game or the Hilton's Sunday brunch.

Henry sleeps under a bridge just off the interstate. Sleep comes only in bits and pieces, so he is exhausted when he gets up at 5 a.m. and stumbles toward the local private enterprise labor pool.

"Will I get work today? Do I want work today?" These questions haunt not only Henry but the 2,000 other men, and some 50 women, who sit in the various downtown labor pools each morning. If a job is offered, most of them must make a choice: to eat or not to eat.

To go out on a job means the worker misses the opportunity for the two meals at the soup kitchens. Stomachs, already groaning from digestive juices sloshing against empty stomach walls, say "Go for the soup kitchen." But a labor pool job, that last glimmer of hope – "maybe today the break will come" – is hard to turn down.

Torn between another day of hunger and \$25 paycheck, Henry chooses food today. So, he will not work. At 6 a.m., sitting in a metal chair not far from the greasy hand-written sign "No Sleeping Allowed," Henry falls asleep.

At 7:30 a.m. Henry pulls his aching body out of the chair and heads to Butler Street C.M.E. Church for the "grits line." There he meets 200 others who stand in line until the door is opened. By 8:15 he has had a cup of coffee, a bowl of grits, a boiled egg, and a vitamin C tablet.

Just as Henry is ready to hit the streets, his bowels yell out. He looks for a place to go to the bathroom, but the church has locked its doors, not wanting the poor and the dirty to use their facilities. So he quickly hides himself behind the dumpster outside.

Atlanta refuses to provide public toilets. One theory offered by a local politician is that if the city provides public toilets, the homeless from all over North American will come to Atlanta! Yet the city spends \$50,000 each year processing the average of four people arrested per day for public urination.

Henry hopes, with his pants below his knees, that no one will see him. When he's finished, a flicker of desire passes through the broken man's heart: "If only I had a few sheets of toilet paper, and maybe just a piece of soap and a little water." But he does not. Now he

stinks. Now, as daylight has filled the city streets, Henry is an enemy of the professional, a discarded person, a punk, wino, and bum, in a local newspaper columnist's terms. He can't even keep himself clean!

Henry wanders toward Grady Hospital downtown. If the guard at the entrance is nice or sleepy, he can wash off there. If the guard is absent he can sit in the waiting room until discovered. Then he can get some of that wet and cold out of his torn socks. He sits and looks at his filthy feet. "Damn, how I wish my left shoe had a sole," he thinks silently to himself, for there is no one with whom to share this most human wish.

When one is poor and carries the terrible burden of homelessness -- having nothing to do but wait -- time moves so slowly. Henry, now with nothing to do except shuffle his way uptown, heads for St. Luke's soup kitchen. Walking hurts; hunger hurts. He longs to travel the mile so he can stand and wait for the soup and sandwich along with 700 other men, women, and children. In the dining hall, music plays in the background, people mumble to themselves about love and lost children, young men without tender fathers search in a macho, violent-prone society for a way to test and prove their manhood. Henry eats his soup.

It's 11 a.m. Henry's day that really never began is almost half over. He now decides to go for the big \$8 job which the medical board allows twice a week: selling his blood plasma. With \$8 he can get cigarettes, a half-pint, and a chicken supper. So Henry, reduced to a man who can only muster the energy and hope for survival, heads off to the blood bank.

After a two-hour wait, his name is called. Slowly he arises from the floor where he has watched a Perry Mason rerun interspersed with advertisements which promise a good life if you will only buy some useless product. Henry walks to the hospital bed and lies down.

Finally, for the first time in five days, he is comfortable. A nurse stands beside him and applies the needle. His blood begins to drip out of his body, and Henry sleeps.

Sleep at the blood bank is unlike sleep anywhere else for the homeless. Here, bleeding, Henry is safe. The temperature is warm, and the noise of the television and the voices in the waiting room are muted by the closed door. Yes, the safest and most comfortable place for a homeless person in all of Atlanta is on the blood bank bed. It's a pity that one can only be there four hours a week.

Henry's day is over. His life, according to many who understand human existence as rooted in a structure of meaning and purposefulness, has been over for years. Homelessness is death. Homelessness is absurd. Homelessness is unnecessary. Homelessness is hell. Homelessness is Henry.

Ed Loring, a Presbyterian minister, is a founding member of The Open Door Community in Atlanta and of Atlanta Advocates for the Homeless. Article reprinted with permission from Sojourners. (800) 714-7474 [www.sajo.net](http://www.sajo.net)

### **ACTIVITY 3 Homelessness: Who, How Many, and Why?**

**Purpose:** To gain a deeper understanding of the causes of homelessness, the breadth of the problem, and who is impacted by it

**Time:** 1 hour

**Materials:** Go to the National Coalition for the Homeless website at [www.nationalhomeless.org](http://www.nationalhomeless.org). Click on *Facts about Homelessness*. Listed under *Basic Facts* you will find three documents:

Why Are People Homeless? (11 pages)

Who is Homeless? (6 pages)

How Many People Experience Homelessness? (6 pages)

Download these documents one at a time and print them out. Make photocopies for each participant in the training, or have participants download their own copies ahead of time.

**Preparation:** Read these documents in advance so as to be knowledgeable about their content.

**Procedure:**

1. Divide the class participants into three groups.
2. Assign each group to read and discuss a different one of the three documents that have been distributed.
3. Instruct each group to then prepare a 5-7 minute presentation that effectively summarizes the content of the paper that was studied. Each member of the group should have some role in the presentation. Encourage the groups to be as creative as possible in their presentation methods while ensuring that a substantive amount of content is conveyed. Approximately 30 minutes total should be allowed for the reading and preparation of presentations.
4. Have the three groups give their presentations to the class with some time permitted after each presentation for questions and answers.

As an alternative to preparing and giving presentations, each group might prepare a quiz on flipchart sheets. The idea behind the quiz is to highlight key points from each paper and put them in a test format, e.g. true or false, multiple choice. Each of the three groups could then administer the quiz to the members of the other two groups.

This could occur in various ways:

- a) Individual participants take the quiz by writing down their responses on an answer sheet and then see how they scored.



- b) Each of the other two groups takes the quiz "as a group" and has a friendly competition to see which group can get the most right answers.
- c) All the participants of the two groups take the quiz and work collaboratively to answer the questions.
- d) Some other creative method, perhaps decided by the group itself.

## **ACTIVITY 4 “In Our Own Words”**

Purpose: To increase understanding and empathy for those experiencing homelessness

Time: 15 minutes

Materials: Handout – “In Our Own Words”

Preparation: Review the handout.

Procedure:

1. Have participants read the handout “In Our Own Words”
2. As individuals or in groups, ask participants to reflect on one or more of the particular statements listed and then provide a possible interpretation of the deeper meaning of what that person might be saying, thinking and feeling about the realities of the experience of homelessness. Encourage participants to use their imaginations about the person’s situation and perceptions.

## In Our Own Words ...

Below is a sampling of quotes from people about their experience of homelessness:

"I feel like a refugee from America"

"I was living on the streets. I was lucky if I could take a shower. I was ashamed and embarrassed of the situation I was in. I felt hopeless, helpless, powerless, jobless."

"Just because you helped me get my money straightened out, don't think you can tell me what to do with it" – client to caseworker

"An old man with no money like me? They'll leave me for last. I don't think they want to bother with me." – regarding going to the hospital

"I was staying at the mission. I had a dislocated shoulder, facing cervical cancer, and I was depressed."

"Yeah, I like to get high but I don't cause any trouble. Why should that bother anybody? I'll bet nobody comes in your home and tells you what to do. I may be in this shelter but I'm not a child ... I'm grown."

"Nothing else ever had the same effect for me. I knew it was 'my' drug the first time I tried it with a friend in high school. She isn't addicted ... I am. Why me? Why not her?" – resident in women's shelter

"It's crazy alright, living on the streets – it can drive you crazy too."

"Shelters? I never went to them. They are unsafe. People always robbed you in shelters. I slept in abandoned cars, parks. It was safer."

"I had health problems. I just thought it was old age. I had arthritis. I had two walking sticks. [And I had] glaucoma. With [my drinking] alcohol, I didn't know how serious it was."

"I was suffering from chronic withdrawals from alcohol. I was afraid. I was afraid to go to the hospital. I was afraid of the diagnosis. When I spoke to the outreach worker, I became less afraid and more confident that I would be able to get help."

"Any day above ground is a good day!"

### Sources:

- *Working with Homeless People: A Guide for Staff and Volunteers* – Columbia University Community Services
- *No Place to Stay* by Elizabeth Fuhr
- Health Care for the Homeless videos – *An Introduction and Outreach*

## **ACTIVITY 5 Video about the Experience of Homelessness**

Purpose: To increase understanding and empathy for people experiencing homelessness

Time: Variable depending on length of the video selected. Plan for about 10-15 minutes of discussion in addition to the length of the video.

Materials: VCR/TV and video

Preparation: Check around to find an educational video that depicts and discusses the experience of homelessness. Your agency or another organization in your community may already have such a video. Public libraries may have relevant materials.

The Health Care for the Homeless Information Resource Center operated by Policy Resource Associates, Inc. has an excellent Video Lending Library. Videos are lent free for 15 days to HCH grantees/subcontractors. Contact via the Internet at <http://www.prainc.com/hch> to view the video-lending catalogue and learn about lending procedures.

Select the video you plan to show and make arrangements to obtain it. Be sure to preview it before showing it to the group so that you can feel confident it is useful and so you have some familiarity with the content ahead of time to help you facilitate discussion afterwards.

Procedure:

1. Introduce and show the video to the group.
2. Facilitate a 10-15 minute open discussion inviting participants' reactions, impressions, and questions.

## **ACTIVITY 6 Homeless for a Day**

Consider setting up an optional experience in which selected participants are given a direct opportunity to experience life on the streets for a brief period of time. This could be for a matter of hours during the day and/or include an overnight experience.

Such an experience, while potentially powerful and valuable, remains limited of course because one who is not truly homeless can never really experience the deeper dimensions of homelessness. However, an experience that approximates the homelessness condition can still leave a real impression.

Setting up this "in vivo" experience would require a great deal of careful planning especially in regard to personal safety and liability issues. Your organization would clearly need to give its approval. An important consideration would be to avoid utilizing limited services (e.g. shelter beds, food) that might deprive other homeless people from accessing them.

## **ACTIVITY 7 Myths and Facts about Homelessness**

Purpose: To examine and counteract common beliefs about homelessness in the society at large

Time: 15 minutes

Materials: Handout: Myths and Facts about Homelessness

Preparation: Review the information on the handout and any other related materials to which you have access.

Procedure:

1. Ensure participants have a copy of the handout from the National Law Center on Homelessness and Poverty.
2. Explain that outreach workers will encounter various attitudes, perceptions, and beliefs about homelessness in their contacts in the larger community. It is useful to be able to respond with accurate information when these beliefs are based on myth more than fact.
3. The handout Myths and Facts about Homelessness identifies five prominent myths accompanied by the actual facts. Review these with the group and allow for discussion as needed.
4. As time permits, invite participants to name other myths about homelessness of which they are aware. As a group, discuss how one might respond to these with accurate information.

National Law Center  
On Homelessness and Poverty

# Myths and Facts about Homelessness

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It is a tragic aspect of our culture that homeless people, in addition to suffering from the hardship of their condition, are subjected to alienation and discrimination by mainstream society. It is even more tragic that alienation and discrimination often spring from incorrect myths and stereotypes which surround homelessness. The following examines some of the myths and the realities about homelessness.

## ***Arrest Records of Homeless People***

**Myth:** Homeless people commit more violent crimes than housed people.

**Fact:** Homeless people actually commit less violent crimes than housed people.

Dr. Pamela Fischer, of Johns Hopkins University, studied the 1983 arrest records in Baltimore and found that although homeless people were more likely to commit non-violent and non-destructive crimes, they were actually less likely to commit crimes against person or property.<sup>1</sup> The report findings are summarized in the following table.

	% of crimes against person or property	% of all other types of crimes
Crimes committed by homeless people	25%	75%
Crimes committed by non-homeless people	35%	65%

## ***The Magnet Theory***

**Myth:** Setting up services for homeless people will cause homeless people from all around to migrate to a city.

**Fact:** Studies have shown that homeless people do not migrate for services. To the extent they do move to new areas, it is because they are searching for work, have family in the area, or other reasons not related to services.

A recent study found that 75% of homeless people are still living in the city in which they became homeless.<sup>2</sup>

## ***The Chronic Theory***

Myth: Homeless people are a fixed population who are usually homeless for long periods of time.

**Fact: The homeless population is quite diverse in terms of their length of homelessness and the number of times they cycle in and out of homelessness.**

Research on the length of homelessness states that 40% of homeless people have been homeless less than six months, and that 70% of homeless people have been homeless less than two years.<sup>3</sup>

Other research on the length of homelessness has identified three primary categories of homeless people:

- transitionally homeless who have a single episode of homelessness lasting an average of 58 days,
- episodically homeless who have four to five episodes of homelessness lasting a total of 265 days,
- chronically homeless who have an average of two episodes, lasting a total of 650 days.<sup>4</sup>

## ***Homeless Population Demographics***

Myth: Homeless people are mostly single men.

**Fact: Families constitute a large and growing percentage of the homeless population.**

A recent study found that families comprise 38% of the urban homeless population.<sup>5</sup> Other research finds that homeless families comprise the majority of homeless people in rural areas.<sup>6</sup>

## ***Employment***

Myth: Homeless people don't work and get most of their money from public assistance programs.

**Fact: Homeless people do work, and a relatively small percentage of them receive government assistance.**

A nationwide study by the Urban Institute in 1987 found that only 20% of 1,704 homeless people received AFDC, GA, or SSI.<sup>7</sup>

A study done in Chicago found that 39% of homeless people interviewed had worked for some time during the previous month.<sup>8</sup>



## ***Substance Abuse and Mental Illness***

Myth: All homeless people are mentally ill or substance abusers.

**Fact: Around a quarter of homeless people are mentally ill, and about 40% are alcohol or substance abusers, with around 15% suffering both disabilities.**

Koegel has researched the prevalence of mental illness among the homeless population and found "between 20% and 25% of those homeless people studied have at some time experienced severe and often extremely disabling mental illnesses such as schizophrenia and the major affective disorders (clinical depression or bipolar disorder)."<sup>9</sup>

James Wright, of Tulane University, has studied the prevalence of alcohol and other drug abuse among the homeless population. He finds that 38% of homeless people are alcohol abusers, as opposed to 10% of the general population. He furthermore finds that 13% of homeless people are drug abusers.<sup>10</sup>

The Center for Mental Health Services states that between 10 and 20% of homeless people suffer "co-occurring severe mental and substance use disorders."<sup>11</sup>

1. James Wright, Memo to NLCHP: *Transiency of Homeless Substance Abusers* 1 (March 11, 1997)
2. Martha Burt, *What We Know About Helping the Homeless and What It Means For HUD's Homeless Programs* Testimony presented to the Housing and Community Development Subcommittee of the Banking and Financial Institutions Committee of the U.S. House of Representatives 1 (March 5, 1997).
3. Dennis Culhane, Testimony presented to the Housing and Community Development Subcommittee of the Pamela Fischer, *Criminal Activity Among the Homeless: A Study of Arrests in Baltimore* 49 (January, 1988).
4. Banking and Financial Institutions Committee of the U.S. House of Representatives, Figure 3 (March 5, 1997).
5. U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1996* (1996)
6. Yvonne Vissing, *Out of Sight, Out of Mind: Homeless Children and Families in Small Town America, 1996* (1996).
7. Martha Burt and Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* 43 (1989).
8. Peter Rossi, *Down and Out in America* 40 (1989).
9. Paul Koegel, *Causes of Homelessness*, Homelessness in America 31 (1996).
10. James Wright, *Homelessness and Health* 68 (1987).
11. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, U.S. Department of Health and Human Services, *Integrating Mental Health and Substance Abuse Services for Homeless People with Co-Occurring Mental and Substance Use Disorders* 1.

# **Module 2: PREPARATION**

## **STARTING ON SOLID FOOTING**

### **Purpose**

The purpose of Module 2 is to help participants become well-prepared for outreach work by identifying the values and skills they bring to the work, exploring dilemmas in outreach, reviewing professional and ethical guidelines, developing healthy self-care practices, understanding risks and establishing safety guidelines for practice, and continuing the journey to become culturally competent outreach workers.

## 2A: Connecting Values and Vision

We have been called to heal the wounds  
To unite what has fallen apart  
And to bring home  
Those who have lost their way.

– St. Francis of Assisi

The world is out of joint  
Oh cursed spite that ever I was born  
To set it right.

– William Shakespeare (Hamlet)

### **Purpose**

For participants to gain a deeper appreciation of how their personal experiences and values inform their work and to develop a personal vision that connects those values with the principles of the Health Care for the Homeless program

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## ACTIVITY 1 River of Life

*Note that Activities 1 and 2 are similar in regard to content. It is recommended that one or the other be used in the training. The River of Life exercise (Activity 1) engages the mind and senses in a more creative way than Activity 2 which is more cognitive-based.*

Purpose: To have participants reflect on personal experiences and influences that have motivated them to become involved in outreach

Time: 15 minutes or more

Materials:

Blank piece of paper and pen for each participant  
Flipchart

Optional:

Multicolored construction paper  
Colored markers, crayons, pens  
Magazines, scissors, glue

Preparation: Gather materials and familiarize yourself with the activity. As preparation, draw your own "river of life." Do this exercise with someone else if possible and share your experiences.

Note that this exercise, particularly the aspect of reflecting on the "rough waters" in one's life, may provoke unwelcome thoughts or memories for some individuals. Comment on this when introducing the "River of Life" exercise and give permission to participants to excuse themselves from doing the exercise if they so choose.

Procedure:

1. Explain that a river is a meaningful symbol in many cultures and that most people find it quite natural and stimulating to think of their own lives in terms of a river. In this activity participants are invited to use the symbol of a river to reflect on their own personal lives.
2. Ask each person to take a piece of blank paper and a pen (or for a more creative approach, provide them with optional materials such as those noted above).
3. On the flip chart write the following:
  - River of life – key stages in your life
  - Tributaries – positive experiences and influences
  - Rough waters – difficult challenges

4. Demonstrate how you might draw the river, tributaries and rough waters and then ask each person to draw their own. Various points on **the river** represent significant stages in one's life. **Tributaries** are drawn to indicate key influences (e.g. people, education, books, experiences, events, etc.) that contributed directly or indirectly to becoming involved in outreach. **"Rough waters"** in the river illustrate those times one has encountered difficult challenges in life that have potentially been the source of valuable learning relevant to this work.

5. Encourage participants to be as self-disclosing in this exercise as is comfortable. Explain that they will be asked to share some of these experiences in small groups of two or three.

6. Allow 5-7 minutes for drawing the river. If using optional materials, give more time for cutting and pasting. Encourage the group to be creative, for example, use colors to express different moods at different periods of their lives.

7. Form groups of two or three to share the experiences illustrated by the rivers. Allow 8-10 minutes for this informal sharing.

8. As closure to the activity, invite anyone who wishes to share with the group any discoveries or insights they might have gleaned from this river excursion.

**Variation for Activity:** Many people view their life as a "pathway" or "roadway" rather than a "river." As facilitator, it is important to be flexible to see which metaphor works best for people. Also, some participants may not feel comfortable drawing. Have them write out their river of life rather than draw it.

(Adapted from "River of Life" exercise in Community Organizing curriculum published by New Mexico Department of Health, Public Health Division, 1994)

## **ACTIVITY 2 What Brings You and What Do You Bring to This Work?**

*Note that Activities 1 and 2 are similar in regard to content. It is recommended that one or the other be used in the training.*

**Purpose:** To reflect on what values and experiences have drawn you to outreach work *and* what strengths, skills, and motivations you bring to the work

**Time:** 25 minutes

**Materials:** Handout: What Brings You and What Do You Bring to This Work?

### **Preparation:**

Familiarize yourself with the activity steps as described below. It is recommended that you complete the exercise for yourself, preferably with a friend or colleague. This will enhance your awareness of the effect of doing the exercise and help you facilitate discussion about it.

### **Procedure:**

1. Ensure that each participant has a handout. Read or summarize the opening paragraphs on the handout as a way of introducing the topic.
2. Ask each person to reflect briefly on each question one at a time and jot down whatever initial responses come to mind. The idea of this exercise is to spur a sampling of ideas, not to be comprehensive. Allow 6-8 minutes for this part.
3. Divide into small groups of 2-3 members. Ask participants to share within the small groups their responses to selected questions. Allow about 10 minutes for this interaction.
4. Reconvene into the large group and spend some time “debriefing” this activity. Any surprises? New insights? Concerns? Affirmations?

# What Brings You and What Do You Bring To This Work?

When you reflect on your current situation, what are the factors and influences that have lead you to do outreach work with people experiencing homelessness? Perhaps you are motivated by certain beliefs and values, or inspired by past experiences, or by someone's example or memory.

Some people can identify very clearly why they've chosen this work. For others, probably most of us, the reasons are less clear. It is not uncommon for workers to say they just kind of "fell into" this work, as if it were an accidental event. It is also not uncommon for these same individuals to come to view themselves as having found their niche or "calling." Few outreach workers view their work as just another job.

Below are some questions to prompt your reflection on how and why you might have become involved in outreach work. Take time to reflect on the questions and jot down what comes to mind.

- 1. When in your life did you first notice you were interested in the "helping professions" or a helping role?*
- 2. What personal life experiences have led you toward this work?*
- 3. What are some of the values and beliefs that influence your work with people experiencing homelessness?*
- 4. What past training/education has helped you prepare for outreach work?*
- 5. Who have been your mentors?*
- 6. What personal skills and attributes do you bring to this work?*
- 7. What concerns or nagging questions do you have about doing outreach?*
- 8. How have you grown or expect to grow personally as a result of your work activities?*
- 9. What are you missing or giving up by being involved in this work?*
- 10. How do you measure success in your work life?*

## **ACTIVITY 3 Creating a Personal Vision Statement**

Purpose: To create a simple personal statement that articulates the worker's vision for doing outreach work with people experiencing homelessness

Time: 20 minutes

Materials: Paper and pen

Preparation: This activity builds upon Activities I and II. The idea is to encourage participants to use their imaginations to create a bold personal statement that speaks to their dreams about what they might be able to accomplish through their outreach work. By definition, a vision statement speaks to values and ideals that are held out as a source of hope and inspiration, even though those ideals are unlikely to be reached.

Prepare for this activity by writing your own personal vision statement and observing your own thought process in doing so. This will help you facilitate others in the process of writing their statements.

Note that vision statements may change over the course of time.

Procedure:

1. Explain that the purpose of this exercise is "to create a bold personal statement that speaks to your hopes and dreams related to your outreach work." To spark participants' imaginations, read the following contrasting "vision statements."

*"We have been called to heal the wounds, to unite what has fallen apart, and to bring home those who have lost their way." Francis of Assisi*

*"The world is out of joint. Oh cursed spite that ever I was born to set it right." Shakespeare (from Hamlet)*

2. Invite everyone to take a pen and paper and spend about 5 minutes writing their own personal vision statement. Assure them that it does not need to be eloquent. Focus on the question: "What is your personal vision related to your outreach work?"

3. Afterward, ask for volunteers to share what they've written to get an idea of the various ways participants responded to this question. You might end the activity at this point, or continue with step #4.

4. Extend the activity by inviting participants to discuss the questions: "What helps you stay focused on your mission?" and "What hinders you from maintaining that focus?" This can be done in small groups or in the large group.



## ACTIVITY 4 “What would you do if ... ?”

*Note that the content covered in Activities 4 and 5 is similar. You may want to choose one of the two.*

Purpose: To “wrestle with” some of the difficult issues that come up in outreach

Time: 30-40 minutes

Materials: Handout: “What would you do if ... ?”

### Preparation:

Set up a “call-in radio show” called “*What Would You Do If?*” You’ll need volunteers from the participant group to act as the talk-show host, to serve as members of a two-person outreach expert panel, and to be callers. Callers will phone in to the show with their outreach dilemmas. These scenarios may be chosen from the handout or callers can make up their own.

The panel of outreach experts, the host, and the caller will discuss the situation among themselves “live on the air.” They will carry on a lively exchange of ideas in hope that some useful insights will come out of the discussion. Volunteers should be rotated among various roles in this activity.

### Procedure:

1. Explain the purpose and setting of the activity. Ask for three volunteers, one to be a radio talk show host, and the other two to serve on an outreach expert panel. Assure the panel members they don’t really have to be “expert” but just to respond as best they can. Those who remain can be callers who “phone in” to the show.
2. Instruct the talk show host to begin by welcoming the panel and listeners to the show. Then invite callers to phone in their outreach dilemmas. Callers should begin their questions with the phrase, “What would you do if ... ?”
3. Encourage a free-flowing interchange among the callers, the panel, the host, and others in the audience. The host, in particular, should occasionally play the role of “devil’s advocate.”
4. After several calls, find new volunteers to serve as the host and expert panel members. Continue the activity for approximately 30-40 minutes or as long as time permits.

# What would you do if ...

... your client who is pregnant admits to you that her boyfriend sometimes punches her in the face and the stomach, but it doesn't happen too often and besides, she really loves him?

... you are told by your supervisor that alcoholic and drug-using clients have to "hit bottom" before they will change and therefore it's a waste of your time to do outreach to these individuals while they're still drinking/using?

... the shelter in which you work is trying to decide whether to "bar" a very psychotic client you've been trying to engage because of rude and offensive comments she has been making to other shelter residents?

... your client, who has a history of several suicide attempts and is currently expressing serious suicidal ideation, refuses to seek treatment voluntarily and states she'll deny having any suicidal thoughts if you attempt to have her involuntarily committed to treatment?

... a homeless youth, who has tested positive for HIV, tells you he makes money to survive by having sex, usually unprotected, with various regular customers?

... a client tells you "in confidence" that she is using false identification to obtain additional food stamps so she can get enough food to eat for herself and her two young children?

... the only way your client will get accepted into housing for which he's been waiting a long time is by "stretching the truth" in your reference statement about the amount of time he's been clean and sober?

... you really need to talk with your supervisor about some dilemmas you're facing in your work, but you have difficulty trusting your supervisor's direction because this person tends to give advice without really listening and understanding the issues you are concerned about?

... the local police ask you to accompany them on their walking beats to help intervene with certain problematic homeless people? (Though the police seem well intended, you wonder about the implications for your outreach work if you are perceived as closely associated with law enforcement personnel.)

... a man living in a homeless encampment down by the river has had a suspicious cough for over a month, but refuses to get it checked out at the clinic nearby, saying it's probably just a smoker's cough?

... local politicians and civic groups, who provide significant funding for your outreach work, are putting pressure on you to do more about "cleaning up the streets" of visibly homeless people in the downtown business district, rather than doing outreach in a more client-centered manner? (In the words of sociologist Peter Marin, they're primary interest is to "cosmetically rearrange the world.")

... your promotion of needle exchange and handing out bleach kits to clients who inject drugs is criticized by your outreach partner as "enabling" clients to continue using drugs?

... a local privately owned apartment building is the only place you can find that will accept your very difficult-to-house client, but you are aware the building is clearly not kept up to code and the landlord has a history of arbitrarily evicting tenants without cause?

... when you ask permission to testify at a local hearing on homelessness, your supervisor tells you that "advocacy is for the advocates, and that you are to spend your time helping people, not doing advocacy?"

... your client who is terminally ill refuses any further treatment and says he just wants to die under the bridge where he has been staying for several years?

... you learn that a client you are working with who is developmentally disabled has been recruited to be a "drug runner" for a dealer, who gives your client money, nice gifts, and special attention?

... you are aware that the disorganized thinking of a client with severe schizophrenia has cleared remarkably in the past when taking psychiatric medications under court-ordered treatment, but he refuses to take medicines voluntarily, is not "committable" and is barely surviving on the streets?

... a homeless individual who refuses to stay in shelters or seek other housing has been recently diagnosed with insulin-dependent diabetes?

... your client, who has remained drug-free since successfully completing long-term residential treatment for his heroin addiction three months ago, tells you he has been having intense cravings to use again?

... your client, who was convicted of a sex offense a year ago when he was in a "blackout," did jail time and was released from jail on probation with the conditions to register as a sex offender and to not drink, has begun drinking occasionally and has been frequently logging on to pornography sites on the computer at the public library?

... a client who you've known a long time who lives under the freeway and has a long history of post-traumatic stress disorder and alcoholism says it's only a matter of time until he's going to commit suicide, but not to worry, because he'll do it alone and no one else will ever know?

... you finally have gotten your client into permanent housing, but it seems to be more of a problem than a solution? (He says he feels walled in, doesn't like being alone, people are constantly knocking at his door wanting to sell him drugs which threatens his own recovery, and he is feeling more and more depressed. He says he was happier living on the streets.)

... your client, who recently moved into drug-alcohol-free transitional housing after successfully completing in-patient treatment, tells you "in confidence" that she's been drinking occasionally, but only on weekends and always away from the transitional housing facility?

... your client tells you that he's proud of himself because he's cut down from smoking crack daily to five days a week?

... (examples from your own experience)

## ACTIVITY 5 Dilemmas in Outreach

"Sometimes it feels like we're trying to do brain surgery with an axe, a screwdriver and a cell phone."

– Heather Barr, HCH public health nurse

*Note that the content covered in Activities 4 and 5 is similar. You may want to choose one of the two.*

**Purpose:** To identify and discuss some of the difficult issues and dilemmas encountered in outreach

**Time:** 30-40 minutes

**Materials:** Flipchart and marker

### Preparation:

Outreach workers are invariably faced with situations that present moral, ethical and/or practical dilemmas. This seems to be the norm more than the exception. Workers learn quickly that the world in which they work is full of "gray areas" in regard to knowing how to proceed. All too frequently, there seems to be no clear-cut, right or wrong approach. Indeed, workers often become "caught in the horns of a dilemma."

Identifying and acknowledging these dilemmas can help workers from being caught off-guard when they arise. It is important that workers are aware of their own reactions to the issues that come up and are able to discuss these matters with their peers and supervisors in order to formulate a proper response.

Think about examples from your own experience as you prepare for this exercise. You might also refer to the handout for Activity IV "What would you do if ...?" for additional ideas to help prompt participants' brainstorming.

### Procedure:

1. Begin by acknowledging that outreach is challenging work. Outreach workers often encounter unique and complex situations for which a clear-cut response is not always evident. Practical and ethical dilemmas will inevitably arise as to what is the best course of action.

2. Ask participants to brainstorm some of the difficult situations or case illustrations they have faced or could imagine facing in outreach. Write these down in "short-hand" on a flipchart. (Consider grouping them if you wish under

more specific categories, e.g. personal rights, interpersonal issues, systems issues, and so forth.)

3. Break into small groups of five or fewer. Assign each group one of the situations/case examples from the brainstorm above. Provide enough details so that the basic context and issues are clear.

4. Explain that each group is to assume the role of the "Outreach Consultation Team" in their agency whose task it is to provide clinical consultation for "sticky issues" that arise in outreach.

5. Instruct the team to take about 8-10 minutes to discuss the case/situation among themselves and prepare a verbal report that reflects their best advice (or at least raises key questions to be addressed) about how to address it. The report should include:

- a) a brief description of the case/situation, including identification of the issues and dilemmas of concern
- b) recommendations about the best course of action to follow (this may include a need for more specific information)

6. Each group then presents the case and their recommendations to the large group (who represent the workers who raised the concern). Some time should be permitted after each presentation for dialogue to take place between the consultation team and the audience.

## **ACTIVITY 6 Professional and Ethical Guidelines for HCH Outreach Workers**

Purpose: To promote the practice of outreach that is consistent with the HCH philosophy of care and adheres to proper behavioral and relational boundaries

Time: 20-30 minutes

Materials: Handout: Professional and Ethical Guidelines for HCH Outreach Workers

### Preparation:

Be acquainted with the material in the handouts and with your agency-specific code of ethics and related policies. Note that *ethics* are defined as “*the principles of conduct governing an individual or a group; a guiding philosophy*” (Merriam-Webster Collegiate Dictionary). Observe also the definition by David Steindl-Rast on the handout: “Ethics is how we behave when we decide we belong together.” While there doesn’t exist a standardized code of ethics for HCH outreach workers, the handout on Professional and Ethical Guidelines for HCH Outreach Workers begins to point in that direction.

### Procedure:

1. Introduce the activity by commenting that because of the unconventional and complex situations that are encountered in outreach, workers sometimes feel compelled to “bend” certain rules or at least make adaptations to their normal way of practicing. This leaves them with a feeling of uncertainty as to whether they’re doing the right thing in a given situation. This activity is designed to acknowledge this reality and to provide some basic guidelines to provide grounding and direction for this work. Remind participants of the importance of “checking in” with supervisors and co-workers in these circumstances.
2. Describe what guidelines are and their purpose. Explain that guidelines are intended to provide a useful framework for decision making in various situations. The guidelines in the handout are to be used as an adjunct to agency-specific guidelines and policies.
3. Go over the specific guidelines on the handout with the group. Invite from the group and/or provide some case examples to illustrate particular guidelines. Some of the guidelines are straightforward whereas others might “raise an eyebrow or two.” Take time to discuss these particular guidelines that raise any questions. Ask if anyone has other ideas not included on the handout.
4. As appropriate, review selected guidelines and policies of your agency that relate to personal and ethical guidelines. Compare them with the guidelines listed in this exercise.

# Professional and Ethical Guidelines For HCH Outreach Workers

"Ethics is how we behave when we decide we belong together."  
David Steindl-Rast

The overriding philosophy of these guidelines is to treat others as you would want to be treated. This applies not only to interactions with clients, but with co-workers, supervisors, staff from other agencies, policy-makers, etc. At the very least, do no harm. It is expected that outreach workers will consistently treat others in a respectful manner and provide competent and compassionate care to clients in whatever forms that care may take.

It is prudent for workers to anticipate and identify ethical dilemmas that arise in outreach and to discuss these issues with supervisors and peers. Some of the guidelines below are intended to prompt such discussions with hopes that adherence to the HCH philosophy of care and practice within proper boundaries will result. These guidelines are to serve as an adjunct to agency-specific codes of ethics and other relevant policies.

- Commit yourself to being well prepared physically, intellectually, emotionally and spiritually for doing this work.
- Develop an awareness of the causes, experience, patterns and politics of homelessness.
- Continually increase your knowledge about homelessness-related health conditions and care, including social service needs and resources.
- Present yourself in a genuine, hospitable manner.
- Maintain a perspective of objectivity with clients. Avoid being judgmental.
- Be respectful of others' desire for privacy and need to keep secrets. Be assertive but not intrusive in your outreach.
- Maintain confidentiality in your relationships.
- Keep your word. Be trustworthy and reliable.
- Respect people as ends, not means. Never exploit clients for personal or agency gain.

- Educate others about behaviors that can enhance their health and well being. Also, inform them of behaviors that might cause them to be susceptible to disease and/or bring harm to themselves or others.
- Don't attempt to intervene in areas in which you are not trained or competent.
- Do not withhold information from clients about other resources and services from which they could benefit.
- Devote some part of your time, no matter how little, to use your knowledge and experience to inform public planning and policy-making processes.
- Refrain from imposing your moral or religious beliefs on others.
- Refrain from having social or emotional relationships with clients outside of work.
- Do not use your own home to shelter clients.
- Never engage in sexual activity with clients.
- Do not accept cash from clients. Accept gifts only when it is culturally appropriate.
- Refrain from giving personal gifts or cash to clients.
- With the possible exception of pepper spray, never carry weapons.
- Never use alcohol or illicit drugs on the job.
- Develop practices of self-care and renewal within and outside the work setting.

(Adapted from the California Association of Community Health Outreach Workers' Code of Ethics and various other sources)



## 2B: Self-Care For Outreach Workers

### **Purpose**

To highlight the importance of taking care of oneself in order to provide effective outreach and engagement services

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

The following issues of *Healing Hands*, the newsletter of the HCH Clinicians' Network, are recommended as background reading for the various activities in this section on self-care.

Sustaining Hope in Poverty Medicine (June 1998)  
[www.nhchc.org/hands/1998/june/junehands.html](http://www.nhchc.org/hands/1998/june/junehands.html)

Coping with Stress, Creating & Maintaining Hope (December 1999)  
[www.nhchc.org/hands/1999/dec/dechands.html](http://www.nhchc.org/hands/1999/dec/dechands.html)

Resiliency and Renewal in Our Work (February 2002)  
<http://www.nhchc.org/hands/2002/February2002HealingHands.pdf>

## **ACTIVITY 1 Self-Care: The Great Debate (Skit)**

Purpose: To acknowledge the “mixed messages” we often hear about self-care in our lives and work settings

Time: 12-15 minutes

Materials: Handout: Self-Care: The Great Debate

Preparation: Based on the handout, envision how you might stage this skit about the “debate” between the *Voice of Self-Care Wisdom* and the *Voice of the Work*. You will need two copies of the handout, some chairs, and possibly some props for the characters – use your imagination!

Procedure:

1. Ask for 5-6 volunteers. Set up an impromptu stage scene using members of the participant group as characters. From these volunteers, choose one person as the Voice of Self-Care Wisdom and another as the Voice of the Work. The remaining 3 or 4 volunteers are a team of Provider Staff in the agency.
2. On stage, the Voice of Self-Care Wisdom is leading a workshop for the Provider Staff. It should be a rather intimate and friendly scene with the staff paying close attention to the Voice of Wisdom. The “Voice of the Work” character can be positioned somewhere off-stage, perhaps even out of sight at the back of the room. Alternatively, the “Voice of the Work” might be positioned right in the midst of the Provider Staff representing both an internal and an external voice.
3. The play begins with the “Voice of Self-Care Wisdom” welcoming the group to the workshop and then beginning to offer sage advice (from the handout) to the staff in an engaging, somewhat lilting voice: “Stop denying. Listen to the wisdom of your body. Begin to freely admit the stresses and pressures that have manifested physically, mentally, or emotionally.” The group listens attentively to these words of wisdom.
4. From afar in a disembodied manner, the “Voice of the Work” intones: “Work until the physical pain forces you into unconsciousness.”
5. Continue the scene in this back and forth manner as the Voices read their parts responsively. The Provider Staff should be instructed to demonstrate corresponding bewilderment on their faces as they listen to these “mixed messages.”
6. At the conclusion of the skit, ask the Provider Staff to comment on how it felt to be caught in the middle of these different “voices.” The audience can be invited to participate as well.

7. Comment that the voices of both *wisdom* and *the work* can come from attitudes and beliefs from within as well as from external sources. Either way, it is important to acknowledge that staff and the organizations for which they work both have legitimate needs that are sometimes at odds. Staff need to find a healthy balance between the two and be aware that this balance may shift at different times. Helping one another to monitor this balance is beneficial.

# Self-Care: The Great Debate

## “The Voice of Self-Care Wisdom” vs. “The Voice of the Work”

**Wisdom:** “Stop denying. Listen to the wisdom of your body. Begin to freely admit the stresses and pressures that have manifested physically, mentally, or emotionally.”

**Work:** *“Work until the physical pain forces you into unconsciousness.”*

**Wisdom:** “Avoid isolation. Don't do everything alone! Develop or renew intimacies with friends and loved ones. Closeness not only brings new insights, but also is anathema to agitation and depression.”

**Work:** *“Shut your office door and lock it from the inside so no one will distract you. They are just trying to keep you from catching up on your paperwork.”*

**Wisdom:** “Change your circumstances. If your job, your relationship, a situation, or a person is dragging you under, try to alter your circumstance, or if necessary, leave.”

**Work:** *“If you feel something is dragging you down, suppress these thoughts. Try drinking more coffee.”*

**Wisdom:** “Pinpoint those areas or aspects that summon up the most concentrated intensity and work toward alleviating that pressure.”

**Work:** *“Increase intensity. Work harder. The harder you work the more people you can help! If you find yourself working at a relaxed pace and enjoying your work, you probably need closer supervision.”*

**Wisdom:** “Stop over-nurturing. If you routinely take on other people's problems and responsibilities, learn to gracefully disengage. Try to get some nurturing for yourself.”

**Work:** *“Attempt to be everything to all people. You exist to solve other people's problems. Perhaps you haven't thoroughly read your job description.”*

**Wisdom:** “Learn to say No. You will help diminish intensity by speaking up for yourself. This means refusing additional requests or demands on your time or emotions.”

**Work:** *“Never say no to anything. It shows weakness, and makes you look like a slacker. Never put off until tomorrow what you can do by working late today.”*

**Wisdom:** “Begin to back off and detach. Learn to delegate, not only at work, but also at home and with friends. In this case, detachment means rescuing yourself for yourself.”

**Work:** *“Delegating is a bad idea. If you want it done right, do it yourself.”*

**Wisdom:** "Reassess your values. Try to sort out the meaningful values from the temporary and fleeting, the essential from the nonessential. You'll conserve energy and time, and begin to feel more centered."

**Work:** *"Reflecting on such things is not only selfish but a waste of time. We will send you a memo explaining how to prioritize your values. Until then, if someone questions your priorities, tell them you are not able to comment and refer them to Personnel. It will be taken care of."*

**Wisdom:** "Learn to pace yourself. Try to take life in moderation. You only have so much energy available. Ascertain what is wanted and needed in your life, then begin to balance work with love, pleasure, and relaxation."

**Work:** *"A balanced life is a myth perpetuated by so-called self-care experts trying to make a buck! They're just trying to undermine your commitment to your work. Don't be fooled by this."*

**Wisdom:** "Take care of your body. Don't skip meals, abuse yourself with rigid diets, disregard your need for sleep, or break the doctor appointments. Take care of yourself nutritionally."

**Work:** *"Yeah, whatever. Your body serves your mind; your mind serves the agency. Push the mind and the body will follow. Drink Mountain Dew."*

**Wisdom:** "Diminish worry and anxiety. Try to keep superstitious worrying to a minimum, it changes nothing. You'll have a better grip on your situation if you spend less time worrying and more time taking care of your real needs."

**Work:** *"If you're not worrying about work, you must not be very committed to it. We may have to find someone else who is."*

**Wisdom:** "Keep your sense of humor. Begin to bring job and happy moments into your life. Very few people suffer burnout when they're having fun."

**Work:** *"So, you think your work is funny? We'll be discussing this with you at a special meeting on Friday, at 7:00 P.M. Be there!"*

(Adapted from Massachusetts Institute of Technology web site at  
<http://web.mit.edu/afs/athena.mit.edu/user/w/c/wchuang/News/college/MIT-views.html>)

## ACTIVITY 2 The Experience of Outreach

Purpose: To help participants appreciate the richness of the experience of outreach ... for both its challenges and frustrations as well as its potential to be rewarding and life-giving

Time: 25-30 minutes

Materials: Handout: "Outreach ..."

### Preparation:

Read the handout, which describes the author's experience of doing outreach. Reflect on your own outreach experience. Perhaps you have written down your own thoughts, feelings and insights in the past. If so, consider sharing these with the group. If not, take some time to jot down some of these reflections in preparation for facilitating this activity.

### Procedure:

1. Begin the activity by taking some time to speak from your own personal experience about what it has been like for you to do outreach. Share any relevant writing you have done, for example, poetry, lyrics, or journal entries. Talk about the reality and nature of outreach work from your perspective and the ways it has impacted and influenced you. You might also include observations from other workers' experience as well.
2. Introduce the interactive part of the activity by noting that outreach workers tend to experience their work as having "both/and" qualities – both challenging and rewarding. Read aloud from the handout: "Outreach ... exhilarating and exhausting ... drives me up a wall and opens doors I never imagined ..." and so forth.
3. Ask participants to spend some time in silence, reflecting initially on the question: What lays heavy, drains you, drives you up a wall, leaves you numb, breaks you apart in this work? Encourage them to jot down whatever comes to mind.
4. After a few minutes, ask participants to consider the question: What feeds and inspires you, gives you joy, makes you feel alive, renews hope, and heals you in this work? Again, urge them to write down their thoughts.
5. Have each person find a partner. Invite them to share with each other what came up during this time of reflection in regard to these two questions. Gauge the amount of time needed for this part of the activity by checking in with the group periodically.

6. Reconvene the group and ask what themes emerged in these interchanges. As will likely become evident, note how the same activities, listening to clients' stories for example, can often be the source of both a sense of burden as well as a gift of inspiration.

## Outreach ...

exhilarating  
*and* exhausting

drives me up a wall  
*and* opens doors I never imagined

lays bare a wide range of emotions  
*yet* leaves me feeling numb beyond belief

provides tremendous satisfaction  
*and* leaves me feeling profoundly helpless

evokes genuine empathy  
*and* provokes a fearsome intolerance within me

puts me in touch with deep suffering  
*and* points me toward greater wholeness

brings me face to face with many poverties  
*and* enriches me encounter by encounter

renews my hope  
*and* leaves me grasping for faith

enables me to envision a future  
*but* with no ability to control it

breaks me apart emotionally  
*and* breaks me open spiritually

leaves me wounded  
*and* heals me

- Ken Kraybill



## **ACTIVITY 3 Signs and Symptoms of Secondary Traumatic Stress**

Purpose: To identify some of the signs and symptoms that outreach workers commonly experience as a result of this work

Time: 15-20 minutes

Materials: Handout: Signs and Symptoms of Secondary Traumatic Stress

### Preparation:

The nature of this work puts us in touch with considerable human trauma and suffering. Working with people experiencing homelessness is like working in "urban refugee camps." Many, if not most, of our clients have been traumatized not only by the circumstances of homelessness, but also by significant physical and/or psychological trauma experiences previously in their lives.

Mother Teresa once said, "Give not only your care, also give your heart." Many dedicated outreach workers do just that. Consequently, by entering into the painful reality of people's lives, workers necessarily will experience some level of suffering in an indirect manner. This experience is variously referred to in the literature as vicarious traumatization, secondary traumatic stress, or compassion fatigue, all of which can lead to burnout.

The symptoms of secondary trauma are identical to those of post-traumatic stress disorder, except that the exposure to trauma is indirect rather than direct. Nonetheless, these signs and symptoms are quite real and very common among outreach workers. Laurence Miller states that "doing trauma (work) is not for everyone. It's tough, grimy, demanding work that can take an exhausting toll on its practitioners." Though referring specifically to trauma psychotherapists, this statement is relevant for outreach workers as well.

Issues regarding secondary traumatic stress need to be acknowledged and addressed as part of training for outreach workers. This activity is designed to name some of the common signs and symptoms of secondary traumatic stress and to have participants reflect on their own past experience and to be aware of potential signals they might experience in the future.

Review the handout and complete it for yourself prior to doing this activity with your training group.

### Procedure:

1. Provide a handout to each participant and request that each completes it.

2. Have participants discuss their comments, questions and insights that result from completing this tool either in pairs, small groups, and/or in the large group, whichever seems most "safe" and appropriate.
3. In addition, discuss with the group practical steps they might take to address specific concerns when they arise. (The following activities in this section will be helpful in this regard.)

# Signs and Symptoms of Secondary Traumatic Stress

Do you experience any of the following as a result of your work?

- Social withdrawal
- Low energy, fatigue
- Feelings of being easily overwhelmed
- Pessimistic or cynical outlook on life
- Intrusive work-related thoughts or dreams
- Difficulty keeping appropriate relationship boundaries
- Difficulty setting limits, saying "no"
- Depressed mood
- Lack of motivation
- Increased worry and anxiety
- Emotional numbness
- Feelings that no one understands (or would be able to)
- Loss of interest in sexual activity
- Vague physical aches, pain
- Making poor judgments and decisions
- Feelings of loss of control
- Increased sense of danger or not feeling safe
- Finding your mind wandering at work
- Difficulty making decisions
- Sense of disconnection from loved ones
- Increased feelings of suspiciousness
- Feeling "adrift" spiritually
- Accident-proneness
- Involvement in "risky" activities (e.g. drugs, alcohol, sexual behaviors)
- Increased irritability, agitation
- Feeling "on edge" much of the time
- Feelings of despair
- Wanting to escape, "run away from it all"
- Increased "sick days" from work
- Violating ethical standards
- Reduced work productivity, doing the "bare minimum"
- Decrease in respect for others, increase in blaming
- Increase in obsessive thoughts and/or compulsive behaviors
- Decreased interest in "self-care"

(Adapted from Traumatic Stress Institute Self Assessment Tool and other similar sources)

## ACTIVITY 4 Self-Care (“Twenty Questions” Game)

Purpose: To spark suggestions and new ideas for ways to practice self-care through a playful, interactive game

Time: 15-20 minutes

Materials: Peel-off nametags that adhere to your clothes

### Preparation:

Be sure you have as many nametags as there are people in the group. Each person will write a self-care activity on the nametag and then stick it on someone else’s back to start the game. The rules of the game are the same as the traditional Twenty Questions game in which each player, asking questions that can be answered only with a “yes” or “no”, tries to guess what’s written on her/his nametag using as few questions as possible.

### Procedure:

1. Hand out the nametags and instruct each person to write any self-care activity they wish on the nametag. Urge them to consider *self-care* in broad terms, including the physical, psychological, spiritual, and social aspects of one’s being. The activity needs to be specific and stated succinctly, in five words or less. Each player is to print the activity in large letters on the nametag.
2. To begin playing, instruct everyone to get up and stick the nametag on someone’s back as they start milling around the room. That individual of course should not know what the nametag says.
3. Each player roams around asking different players questions that can only be answered with “yes” or “no” answers. From these responses, the player attempts to deduce what is written on the tag on her/his back.
4. The responding player must have read the other person’s nametag of course in order to know whether to answer affirmatively or not.
5. As each player correctly guesses the activity on his or her nametag, the tag is transferred from the back to one’s chest and continues to play by answering other player’s questions. The game continues until everyone has guessed (or given up guessing) the activity on his or her back.
6. Take a few minutes to “debrief” the game experience to see what new ideas it might have sparked in regard to self-care.

## **ACTIVITY 5 Self-Assessment Tool: Self Care**

Purpose: To use a self-assessment tool to rate yourself in the areas of physical, psychological, emotional, spiritual, and workplace self-care

Time: 15 minutes

Materials: Handout: Self-Assessment Tool: Self Care

Preparation: Complete the self-assessment tool yourself and think about your responses to the follow up questions listed below. Alternatively, do this exercise with another person, or small group, and discuss it among yourselves.

Ensure you have a copy of the tool for each participant.

Procedure:

1. Hand out a copy of the self-assessment tool to each participant and request that each one takes about 5-7 minutes to complete it. Emphasize that this is not an all-inclusive list, but a representative list of self-care activities. In addition, it should not be inferred that everyone should be doing all the things mentioned here. This tool simply provides a snapshot of one's current state of self-care.
2. Once completed, discuss in pairs, in small groups, and/or as a large group what ideas and issues it raised. Below are some possible questions to which participants might respond:

*Were there any surprises? New ideas you hadn't really thought of before?*

*Which activity ideas seem like they would be more a "burden" than a benefit to you?*

*What are you already doing to practice self-care in the physical, mental, emotional, spiritual, and workplace realms?*

*What activities particularly spark your interest? How might you incorporate them into your life sometime in the future?*

*What is one activity or practice you would like to "try on for size" starting now or as soon as possible?*

# SELF-ASSESSMENT TOOL: Self Care

(Adapted from Saakvitne & Pearlman & TSI Staff,  
Transforming the Pain: A Workbook on Vicarious Traumatization, 1996).

*How often do you do the following? (Rate, using the scale below):*

**5 = Frequently**

**4 = Occasionally**

**3 = Sometimes**

**2 = Never**

**1 = It never even occurred to me**

## Physical Self Care

- Eat regularly (e.g. breakfast & lunch)
- Eat healthfully
- Exercise, or go to the gym
- Lift weights
- Practice martial arts
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when you're sick
- Get massages or other body work
- Do physical activity that is fun for you
- Take time to be sexual - with yourself, with a partner
- Get enough sleep
- Wear clothes you like
- Take vacations
- Take day trips, or mini-vacations
- Get away from stressful technology such as pagers, faxes, telephones, e-mail
- Other:

## Psychological Self Care

- Make time for self-reflection
- Go to see a psychotherapist or counselor for yourself
- Write in a journal
- Read literature unrelated to work
- Do something at which you are a beginner
- Take a step to decrease stress in your life
- Notice your inner experience - your dreams, thoughts, imagery, feelings
- Let others know different aspects of you
- Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event
- Practice receiving from others
- Be curious
- Say no to extra responsibilities sometimes
- Spend time outdoors
- Other:

### **Emotional Self Care**

- Spend time with others whose company you enjoy*
- Stay in contact with important people in your life*
- Treat yourself kindly (supportive inner dialogue or self-talk)*
- Feel proud of yourself*
- Reread favorite books, review favorite movies*
- Identify comforting activities, objects, people, relationships, places - and seek them out*
- Allow yourself to cry*
- Find things that make you laugh*
- Express your outrage in a constructive way*
- Play with children*
- Other:*

### **Spiritual Self Care**

- Make time for prayer, meditation, reflection*
- Spend time in nature*
- Participate in a spiritual gathering, community or group*
- Be open to inspiration*
- Cherish your optimism and hope*
- Be aware of nontangible (nonmaterial) aspects of life*
- Be open to mystery, not knowing*
- Identify what is meaningful to you and notice its place in your life*
- Sing*
- Express gratitude*
- Celebrate milestones with rituals that are meaningful to you*
- Remember and memorialize loved ones who are dead*
- Nurture others*
- Have awe-ful experiences*
- Contribute to or participate in causes you believe in*
- Read inspirational literature*
- Listen to inspiring music*
- Other:*

### **Workplace/Professional Self Care**

- Take time to eat lunch*
- Take time to chat with co-workers*
- Make time to complete tasks*
- Identify projects or tasks that are exciting, growth-promoting, and rewarding for you*
- Set limits with clients and colleagues*
- Balance your caseload so no one day is "too much!"*
- Arrange your workspace so it is comfortable and comforting*
- Get regular supervision or consultation*
- Negotiate for your needs (benefits, pay raise)*
- Have a peer support group*
- Develop a non-trauma area of professional competence*
- Other:*

## **ACTIVITY 6 Mindfulness and Self-Care for Outreach Workers**

Purpose: To identify some practical methods to integrate mindfulness into everyday life and work as a way of handling ongoing stress

Time: 15 minutes

Materials:

Handout: Mindfulness and Self-care for Outreach Workers

Resource Paper: Mindfulness and Mastery in the Workplace: 21  
Ways to Reduce Stress during the Workday

Preparation:

Read the resource paper and the handout. The handout was inspired by and adapted from the Mindfulness and Mastery in the Workplace paper.

Ensure each participant has a copy of the handout.

Procedure:

1. Introduce the topic by explaining that self-awareness/mindfulness is foundational to self-care, which is foundational to caring for others.
2. Share any insights you may have gleaned from the Santorelli resource paper. Read or tell the *Little Green Dots* story as an example of mindfulness and mastery in the work setting.
3. Have the group take some time to review the "modest proposals" on the handout: Mindfulness and Self-care for Outreach Workers. Facilitate a group discussion focusing on which ideas resonate with them, ideas they find intriguing and want to explore further, and other additional ideas participants they might have.



# Mindfulness and Self-care for Outreach Workers

*"We have been called to heal the wounds  
To unite what has fallen apart  
And to bring home  
Those who have lost their way."*

*St. Francis of Assisi*

## *Some modest proposals ...*

- ◆ When you awaken, express gratitude for the new day ... for having a home ... for your health ... friendships ... for your work ... your clients
- ◆ Eat a nourishing breakfast
- ◆ Offer a gift of hospitality to those you meet throughout the day by "creating a free and friendly space" for them (Henri Nouwen)
- ◆ Consider that caring for others is also a way of caring for yourself
- ◆ When caught up in a stressful situation ask, "what is the most important thing right now?"
- ◆ Practice new ways of seeing – "you can look at a scar and see hurt, or you can look at a scar and see healing." (Sheri Reynolds)
- ◆ Offer yourself to others in your "emptiness" as well as your "fullness"
- ◆ Try drinking water or fruit juice instead of carbonated beverages. Monitor your intake of alcohol, caffeine, salt, and sugar.
- ◆ Talk out loud (preferably with someone else!) about your daily experiences in outreach
- ◆ Express appreciation for the work of the "support staff" in your organization ~ receptionists, janitors, data entry, administrators
- ◆ Reflect on the root meaning of the word "care" ... to lament, to grieve, to experience sorrow, to cry out with
- ◆ Create a personal mission statement related to your work

- ◆ Identify the ways in which your work both depletes and feeds you personally
- ◆ Imagine yourself a biographer when writing your chart notes, recording some part of another person's story
- ◆ Before you pick up that ringing phone or dial to make a call ... take a deep, renewing breath
- ◆ Choose things that inspire you – art, flowers, fresh fruit, sayings, pictures of people – to decorate your workspace (if you have one)
- ◆ Invite students from a local massage school to come practice their skills on staff and clients in your work setting
- ◆ Start a “wit and wisdom” file
- ◆ Do one thing at a time
- ◆ Permit yourself time to be silent
- ◆ Consider that “a rose withholds its scent from no one ... a tree does not discriminate to whom it provides shade” (Anthony DeMello)
- ◆ Be forgiving
- ◆ Remember, it's the little things that count
- ◆ Do things outside of work that nurture you. Try out new activities.
- ◆ If you feel a little too busy ... stop and take 10 conscious, deep, diaphragmatic breaths
- ◆ If you feel moderately busy ... stop and take 20 conscious, deep, diaphragmatic breaths
- ◆ If you are excessively busy and feel overwhelmed ... stop and take 30 conscious, deep, diaphragmatic breaths
- ◆ After taking deep breaths, pause when finished and feel the energy you have generated
- ◆ Create a rhythm of action and contemplation in your workday
- ◆ When you go to bed at night, express gratitude for the day you were given ... for having a home ... for your health ... friendships ... for your work ... your clients

 SAKI F. SANTORELLI

## ***Mindfulness and Mastery in the Workplace:***

### ***21 Ways to Reduce Stress during the Workday***

THIS ARTICLE EMERGED out of a conversation initiated by Thich Nhat Hanh following the conclusion of a five-day mindfulness retreat in 1987. He had asked the participants to speak together about practical methods they used to integrate mindfulness into everyday life. Most people reported that this was a struggle and that the "how" of doing so was at best, elusive. Since this has been an explicit focus of our approach at the Stress Reduction Clinic, after talking about the clinic work and my own attempts to weave practice into the fabric of my everyday life, Amie Kotler, who also participated in the discussion and is the editor of Parallax Press, asked me to write this article.

Over the past seventeen years, the Stress Reduction Clinic at the University of Massachusetts Medical Center has introduced more than 8,000 people to mindfulness practice. The clinic is the heart of an over-arching community known as the Center for Mindfulness in Medicine, Health Care, and Society and offers medical patients a substantive, educationally oriented approach we call *mindfulness-based stress reduction (MBSR)*.

As an instructor, I have had the good fortune of working with several hundred patients/participants each year. In the context of preventive and behavioral medicine, mindfulness practice is a vehicle that assists people in learning to tap deep internal resources for renewal, increase psychosocial hardiness, and make contact with previously unconceived of possibilities and ways of being. Besides well-documented reductions in both medical and psychological symptoms, participants report an increased sense of self-esteem, shifts in their sense of self that afford them the ability to care for themselves while better understanding their fellow human beings, a palpable deepening of self-trust, and for some, a finer appreciation for the preciousness of everyday life.

In addition to this ongoing clinical work, I have the opportunity to teach in a wide variety of settings in both the public and private sectors. These programs are tailored to individual, corporate, or institutional needs with an underlying emphasis on the cultivation and application of mindfulness and mastery in the workplace. Out of one such program evolved: *21 Ways to Reduce Stress During the Workday*.

During a follow-up program for secretarial staff, I was moved by their struggle to practically integrate the stability and sense of connectedness that they sometimes felt during the sitting meditation practice into their daily lives while at work. In response to their struggle, "21 Ways" came into print. In developing these ways, I proceeded by simply asking myself: How do I attempt to handle ongoing stress while at work? -- actually from the time I awaken in the morning until I return home at the end of the formal workday. How do I attempt to stitch mindfulness into the cloth my daily life? What helps me to wake up when I have become intoxicated by the sheer momentum and urgency of living?

Mindfulness harnesses our capacity to be aware of what is going on in our bodies, minds, and hearts in the world -- and in the work place. As we learn to pay closer attention to what is occurring within and around us, one thing we begin to discover is that we are swimming in an unavoidable sea of constantly changing events. In the domain of stress reactivity, the technical term for this fluctuating reality is called a *stressor*. Stressors are ever-present events that we are continually adapting to. Some tend to be met with ease and others draw us away from our sense

of stability. The crucial difference in our responses to stressors usually has to do with fear and our perception of feeling threatened or overly taxed by an event, be it either internal or external in origin. Seen from a psychological viewpoint, stress is a relational *transaction* between a person and her environment. From this transactional point of view, our perception and appraisal of the events as either being over-taxing to our inner and outer resources (threatening) or capable of being handled makes a tremendous difference.

Because many of our perceptions and appraisals are operating below the current threshold of our awareness, often we don't even know that our resources are being overly taxed. Conversely, because we have all been conditioned by habit and history, events that are not, or may no longer be threatening are often reacted to as if they are threatening. Therefore, developing our ability to see and understand what is going on inside and around us is an essential skill if we are to be less subject to these unconsciously driven reactions.

Changing the way we see ourselves in relationship to events actually alters our experience of those events, their impact in our lives, as well as our capacity to maintain our well being in the midst of such events. Given this viewpoint, the cultivation of mindfulness -- our capacity to be aware and to understand ourselves and the world around us -- is crucial to our ability to handle stress effectively.

Primarily, what the secretaries were struggling with was the gap between the awareness and stability they were beginning to touch in the domain of formal practice, and the dissipation of awareness and consequent dissonance experienced in the workday environment and their usual "workday mind." What they wanted was a vehicle for integrating "formal practice" into everyday life.

Although this need for integration is the same for all of us, notions about how to work in such a manner remain largely conceptual unless we develop concrete ways of practicing that transform theory into a living reality. This is exactly what the "21 Ways" provided. The participants got enthusiastic about these suggestions because it provided them something solid to work with when attempting to "bridge the gap" and integrate mindfulness into their workplace.

Since then, I have shared these "ways" with many workshop participants and continue to receive letters and telephone calls from people who have either added to the list or posted them as convenient reminders in strategic locations such as office doorways, restroom mirrors, dashboards, and lunch rooms. I've been gladdened to hear from them and happy that by its very nature, the list is incomplete and therefore full of possibility.

Each of these "21 Ways" can be seen as preventive -- a strengthening of your stress immunity, or as recuperative -- a means of recovering your balance following a difficult experience. Most importantly, they are methods for knowing, and if possible, modifying our habitual reactions in the midst of adversity. As you begin working with this list you'll notice that it includes pre-, during, and post-work suggestions. Although arbitrary, these distinctions might be initially useful to you. Incorporating awareness practice into your life will necessitate a skillful effort that includes commitment, patience, and repetition. It may be helpful to think of yourself as entering a living laboratory where the elements of your life constitute the ingredients of a lively, educational process. Allowing yourself to be a beginner is refreshing. Give yourself the room to experiment without self-criticism. Allow your curiosity to carry you further into the *process*.

At the heart of workday practice is the intention to be aware of and connected to whatever is happening inside and around us (mindfulness) as well as the determination to initiate change when called for (mastery). A useful example of this process is revealed in the following story told to me some years ago by a physician friend. I call this story, *Little Green Dots*.

My friend told me that as his practice grew busier and more demanding, he began to develop

minor, transient symptoms that included increased neck and shoulder tension, fatigue, and irritability. Initially, these symptoms were benign, disappearing after a good night's rest or a relaxing weekend. But as his medical practice continued to grow, the symptoms became persistent and, much to his chagrin, he noticed that he was becoming a "chronic clock-watcher."

One day, while attending to his normal clinical duties, he had a revelation. He walked over to his secretary's supply cabinet and pulled out a package of "little green dots" used for color-coding the files. He placed one on his watch and decided that since he couldn't stop looking at his watch, he'd use the dot as a visual reminder to center himself by taking one conscious breath and dropping his shoulders.

The next day he placed a dot on the wall clock because he realized, "If I'm not looking at the one on my wrist, I'm looking at the one on the wall." He continued this practice and by the end of the week he had placed a green dot on every exam room doorknob. A few weeks after initiating this workday practice, he said that much to his own surprise, he had stopped, taken a conscious breath, and relaxed his shoulders one hundred times in a single day. This simple, persistent decision to be mindful had been for him, transformative. He felt much better. Most importantly, his patients began telling him that he was "much more like himself." For him, that was the icing on the cake.

The story is simple and direct. Using what is constantly before us as a way of awakening to our innate capacity for stability and calmness is essential if we wish to thrive in the midst of our demanding lives.

Years ago, while working with a group of harried receptionists who described their reaction to the telephone ring as feeling much like Pavlov's dogs, I suggested that they use the first ring of the telephone as a reminder to take one breath, return to themselves, and then pick up the phone. For many, this simple practice became a powerful agent of change. Some said that people they had spoken with for years on the telephone didn't recognize their voices. Clients told them that they were speaking in a more measured pace and their voices had settled into the lower ranges. For the receptionists, the telephone no longer elicited the usual patterned reaction. They had learned to respond to this relentless, invasive, ubiquitous sound rather than to react. Through the action of awareness, the ring of the telephone had shifted from an object of unconscious threat and demand to a vehicle for cultivating greater awareness and skillful action.

Having experimented with the "green dots" on my own watch, I have found that like any other method, they can quickly sink into the realm of the unconscious. Pretty soon, like the second hand, numbers, or date indicator, the dots become just another part of the watch face, completely unseen, of no help -- actually perpetuating more unawareness.

No matter what is chosen as a reminder, our real work is to remember. This remembering is called mindfulness.

The following "21 Ways" are simply a road map. Allow your curiosity and the sense of possibility to unfold as you explore the territory, discovering your own "ways."

### *21 Ways to Reduce Stress During the Workday*

1. Take five to thirty minutes in the morning to be quiet and meditate, and/or lie down and be with yourself...gaze out the window, listen to the sounds of nature, or take a slow quiet walk.
2. While your car is warming up, try taking a minute to quietly pay attention to your breathing.
3. While driving, become aware of body tension, e.g. hands wrapped tightly around the steering wheel, shoulders raised, stomach tight, etc., consciously working at releasing, dissolving that tension...Does being tense help you to drive better? What does it feel like to relax and drive?
4. Decide not to play the radio and be with your own sound.

5. On the interstate, experiment with riding in the right lane, going five miles below the speed limit.
6. Pay attention to your breathing and to the sky, trees, or quality of your mind, when stopped at a red light or toll plaza.
7. Take a moment to orient yourself to your workday once you park your car at the workplace. Use the walk across the parking lot to step into your life. To know where you are and where you are going.
8. While sitting at your desk, keyboard, etc., pay attention to bodily sensations, again consciously attempting to relax and rid yourself of excess tension.
9. Use your breaks to truly relax rather than simply "pausing." For instance, instead of having coffee, a cigarette, or reading, try taking a short walk -- or sitting at your desk and renewing yourself.
10. For lunch, try changing your environment. This can be helpful.
11. Try closing your door (if you have one) and take some time to consciously relax.
12. Decide to stop for one to three minutes every hour during the workday. Become aware of your breathing and bodily sensations, allowing the mind to settle in as a time to regroup and recoup.
13. Use the everyday cues in your environment as reminders to "center" yourself, e.g. the telephone ringing, sitting at the computer terminal, etc.
14. Take some time at lunch or other moments in the day to speak with close associates. Try choosing topics that are not necessarily work related.
15. Choose to eat one or two lunches per week in silence. Use this as a time to eat slowly and be with yourself.
16. At the end of the workday, try retracing today's activities, acknowledging and congratulating yourself for what you've accomplished and then make a list *for tomorrow*. You've done enough for today!
17. Pay attention to the short walk to your car -- breathing the crisp or warm air. Feel the cold or warmth of your body. What might happen if you open up to and accept these environmental conditions and bodily sensations rather than resist them? Listen to the sounds outside your workplace. Can you walk without feeling rushed? What happens when you slow down?
18. At the end of the workday, while your car is warming up, sit quietly and consciously make the transition from work to home -- take a moment to simply *be* -- enjoy it for a moment. Like most of us, you're heading into your next full-time job -- home!
19. While driving, notice if you are rushing. What does this feel like? What could you do about it? Remember, you've got more control than you might imagine.
20. When you pull into the driveway or park on the street, take a minute to orient yourself to being with your family members or to entering your home.
21. Try changing out of work clothes when you get home. This simple act might help you to make a smoother transition into your next "role" -- much of the time you can probably "spare" five minutes to do this. Say hello to each of your family members or to the people you live with. Take a moment to look in their eyes. If possible, make the time to take five to ten minutes to be quiet and still. If you live alone, feel what it is like to enter the quietness of your home, the feeling of entering your own environment.

## **ACTIVITY 7 Self-Care in the Workplace**

Purpose: To identify specific self-care practices for agency staff to implement in the work setting

Time: 30-45 minutes

Materials: None

Preparation: Read the activity instructions below and prepare accordingly.

Procedure:

1. Form small groups of about 4-6 participants.
2. Each group is to envision themselves being at a staff retreat with a focus on self-care in the workplace. The task of each group is to come up with a proposal for a staff self-care plan for the coming year. Encourage the groups to think imaginatively and brainstorm specific ideas that could be implemented.  
Some examples:
  - personal check-ins at the beginning of staff meetings
  - staff potlucks
  - a visiting massage therapist
  - special recognition of birthdays/work anniversaries
  - review of agency personnel policies in regard to staff self-care
  - retreats in nature
  - form a staff softball/volleyball/soccer team
  - time and space for meditation or yoga
  - "De-stress the Workplace Month"
  - diverse activities in job descriptions
  - flexible work schedules
3. After brainstorming ideas, each group is to prepare a presentation for the larger group about their plan. The following conditions apply to the presentation:
  - The group is to present approximately 3-5 specific and viable recommendations for implementation
  - All members of the group are urged to participate in the presentation
  - The presentation itself is to take five minutes or less
  - The recommendations should be presented in an interesting and creative way. No dry, didactic reports or speeches permitted! (The performance of skits, songs, limericks, haiku, games, role-plays, etc. is highly encouraged.)
4. Give each group approximately 15-20 minutes for brainstorming ideas and planning their presentation according to the conditions noted above. Then have

them make their presentations. Consider giving prizes for the most creative, clever, and humorous self-care ideas and/or presentations.

5. Conclude the activity by discussing the most viable ideas that were raised and challenge participants to consider ways to implement them in their own work settings.



## **ACTIVITY 8 Video: "Blaze of Glory Should Not Equal Burnout"**

Purpose: "In this highly engaging presentation, psychologist Dr. Terry Tafoya describes how clinicians can effectively channel the stress associated with burnout into positive personal growth." (from the video jacket)

Time: Running time is 82 minutes. Add at least 10 minutes for discussion.

Materials:

TV/VCR player and a copy of the video *"Blaze of Glory Should Not Equal Burnout: Caring For the Caregiver"*

This is a videotape of Dr. Tafoya's presentation on self-care at the First Health Care for the Homeless Clinicians' Network Meeting in Washington, DC June 6, 1996. The video was produced by the Bureau of Primary Health Care, Division of Programs for Special Populations, in collaboration with the HCH Clinicians' Network.

The videotape was distributed to all HCH projects in 1996. If you cannot find a copy in your local project, contact the National Clearinghouse on Primary Care Information at 1-800-400-2742.

Preparation:

Preview the video if possible so you'll be better prepared to discuss it. As you watch it, note the humor and wisdom as it's conveyed through symbols, saying and stories.

Procedure:

1. Introduce and show the videotape.
2. Take ample time afterwards to discuss some of the main themes presented in the video and their relevance for the participants.

## **2C: WORKER SAFETY – PRECAUTIONS & INTERVENTIONS**

### **Purpose**

To increase workers' awareness of health and safety risks in outreach and to promote prevention efforts and guidelines for intervention

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 What Risks?**

Purpose: To have workers anticipate and identify those health and safety risks they are likely to encounter in outreach

Time: 20-30 minutes

Materials:

Flip chart and markers  
4"x6" cards and masking tape

Preparation:

The outreach worker's work setting is a unique and ever-changing environment. Taking services to "where people are" presents intriguing and unique possibilities for where a worker's daily sojourn might lead. Outreach also presents certain risks for the worker's health and safety. Employers need to fully inform workers of these risks and workers need to take these matters seriously. Workers must commit themselves to abide by agency policies, maintain awareness of their environment, and to be well prepared to minimize these risks.

Familiarize yourself with the procedure as outlined below. The method described is an effective way to help groups engage in creative brainstorming and subsequently begin to define the issues in more measurable terms.

Procedure:

1. Break into small groups of 3-5.
2. Ask each group to brainstorm the various kinds of health and safety risks outreach workers encounter. Encourage them to think broadly. For example, remind them to define health not only in physical terms, but in relation to one's psychological, emotional and spiritual health as well. Urge participants to freely brainstorm ideas that come to mind without regard to how insignificant or "off the wall" they might appear. Often by voicing such ideas, other ideas are spawned.
3. Ask each group to choose around 10-15 risks from those they brainstormed and write each one down on a 4"x6" card or larger. Express the idea briefly in five words or less and write it in legible letters. (It's meaning can be expanded upon verbally later in the exercise.)
4. Have each group take turns bringing three of their cards at a time to the front of the room and place them on a flipchart, board or wall with masking tape or other suitable fastening method. Each group should choose three different ideas than those already presented. Groups can explain at this time what their ideas mean if they need elaboration.

5. After this first round of ideas has been presented, have the group assist in grouping the ideas. For example, groupings likely to emerge will include: exposure to diseases, accidents, physical violence, harassment or verbal/emotional abuse, emotional/psychological symptoms, burnout, etc.

6. Ask for additional rounds of ideas until all the different brainstorm ideas have been put on the board. Continue to group them.

7. Although the primary intention of this exercise is to simply identify areas of risk, you might use this opportunity to prioritize those issues that need to be addressed further and how and when that will occur.

*Note:* Another approach to this activity is to simply have participants call out various health and safety risks and to group these ideas as you go.

## **ACTIVITY 2 Safety Guidelines for Street Outreach**

Purpose: To identify and generate discussion about safety guidelines in street outreach

Time: 20-25 minutes

Materials: Handout: Safety Guidelines for Street Outreach

Preparation: Review the guidelines noted on the handout. Note the opening statement: "These safety guidelines for street outreach are adapted from guidelines developed by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street. They do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach worker who operates in a very different work environment than staff who are agency-based. The guidelines are intended as only one part of an agency's overall safety policies and procedures."

Procedure:

1. Review the guidelines together as a large group. Comment on selected guidelines as you see fit. Also, provide examples from your own experience. It may be helpful to give examples of situations when workers did not adhere to guidelines or agency policies and experienced negative consequences as a result.
2. Invite participants to ask questions and give their own illustrations.
3. As facilitator, even when the truth of a guideline seems self-evident, ask why it was included on the list. Play the role of "devil's advocate" periodically to urge the group to think more deeply about these guidelines.
4. After reviewing the guidelines on the handout, ask the group for other guidelines they would add to the list. Some workers who do outreach in specific settings or with specific populations will generate guidelines that may be unique to their situation.

# Safety Guidelines for Street Outreach

These safety guidelines for street outreach are adapted from guidelines developed by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street. They do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach worker who operates in a very different work environment than staff who are agency-based. The guidelines are intended as only one part of an agency's overall safety policies and procedures.

1. Your supervisor needs to know where you will be at all times.
2. Learn as much as possible about the situation before setting out to do outreach.
3. Do not plan outreach in areas which you have good reason to believe are inherently dangerous.
4. Be aware of gang areas and their colors. Avoid wearing those colors.
5. Always carry business cards and identification with you.
6. Inform collaborating agencies of your presence.
7. Introduce yourself and inform people of what you are doing and why.
8. Do not stand and argue with someone who does not agree with what you are doing.
9. Outreach is preferably conducted in two-person teams. No team member should conduct outreach activities alone unless receiving prior approval from their supervisor.
10. Do not approach those who are giving "signs" that they do not want to be bothered.
11. Do not be critical of your partner in public while conducting outreach. Always present yourselves as a team.
12. Wear comfortable clothes and shoes. Do not overdress.
13. Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, laptops, etc. If carrying incentives, make arrangements to hold these in a secure place.

14. Do not remain in a spot where you are privy to a drug deal in process or is being set up to "go down." Leave the area immediately without drawing attention to yourself or others.
15. Do not linger with a person who you know is holding illicit drugs.
16. Do not interrupt the sale of sex or drugs for money. Leave the area immediately without drawing attention to yourself or others.
17. Do not counsel or play the role of a social worker on the streets.
18. Maintain confidentiality with all clients you meet.
19. Do not accept gifts, food or buy any merchandise from clients.
20. Do not give or lend money to clients.
21. Do not accept or hold any type of controlled substance.
22. Never enter any clients' cars, homes or any enclosed area.
23. Tell clients approximately when you will be back and where you can be reached. Provide clients with a business card.
24. Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor.
25. Keep your supervisor informed of any unusual developments.
26. In case of an emergency, call or have another person call 911. Do not separate from your partner unless you feel that staying would increase your danger.

**Employee Statement:**

I acknowledge that I have received a copy of the safety guidelines for performing outreach. I certify that I have read and understand these guidelines, and I agree to comply with agency guidelines related to this issue to the best of my ability.

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **ACTIVITY 3 Guidelines for Addressing Aggressive Behaviors**

Purpose: To review, discuss, and role-play effective ways to address clients' aggressive behaviors

Time: 45-50 minutes

Materials:

Resource Paper: Wasatch Homeless Health Care Program Safety Protocol

Handout: Wasatch Homeless Health Care Program Safety Manual

Preparation: Review the resource paper and handout to prepare for a presentation on "Guidelines for Addressing Aggressive Behaviors." The main points for your presentation are outlined in the Safety Manual that has been developed by the Wasatch Homeless Health Care Program in Salt Lake City, Utah. Note that these materials are taken from *Sample Safety Guidelines in Homeless Health Services Programs* compiled by the Health Care for the Homeless Clinicians' Network (1996).

Procedure:

1. Provide about a 20-25 minute presentation using examples and including time for questions and discussion. Focus your presentation on:
  - Purpose and importance of having safety guidelines
  - Acknowledgement of client stress and special extenuating circumstances that influence their behaviors
  - Three levels of intervention: prevention, de-escalation of tension, and action aimed toward safety for all individuals involved
  - Four basic steps: observing, skilled listening, talking, and taking action.
2. Break into groups of three and set up a role-play situation between two individuals: an aggressive client and an outreach worker. The third person is a witness-observer to the interaction who acts as a "coach" for the worker during and after the role-play. Instruct the client to pick an issue and act in an angry, aggressive manner, short of physical violence, towards the worker. The outreach worker is to practice the skills just discussed to try to de-escalate the client. Provide ample time so that everyone gets to play each of the three roles.
3. Take time to debrief the role-play experience with the group. *What was it like to be in the various roles? What de-escalation skills worked well? Which ones didn't? What did participants learn?*



# Wasatch Homeless Health Care Program Safety Protocol

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## **Goals & Priorities**

The primary goal of the Wasatch Homeless Health Care Program is to interact with patients in such a manner that prevents the escalation of negative actions and potentially violent situations. The secondary goal is to persuade patients who act out to leave the premises willingly and quietly.

In order to achieve these goals, we must establish behavior guidelines that enable us to identify problem behaviors and deal with them effectively and appropriately before they escalate into a crisis situation. In order of priority, these are the personnel who will be involved with problem clients:

1. Front desk personnel and dental personnel who receive patients and make appointments are usually first to encounter possible difficulties.
2. Medical assistants and dental assistants are second in this role.
3. Medical and dental providers, other staff and volunteers are usually last in this interaction process.

Regardless of our role, however, when serving patients we are equally responsible for our own behavior and for protecting the security of co-workers.

## **Guidelines**

Here are guidelines to follow in our everyday interactions with patients. In order to promote workable relationships, we must address our patients with respect and kindness. It is imperative that we do not react to verbal abuse with anger or disrespect. Instead, we should remain calm and in control. Occasionally patients use aggressive and intimidating tactics to get what they want. It is important that we be aware of this type of behavior and learn to respond without being manipulated.

- Answer patients' questions assertively and assure them that they will be seen as soon as possible or according to their respective appointments.
- Do not offer lengthy explanations or excuses. Responding in this manner may increase the patient's frustration level.
- Simply state the facts and repeat them if necessary. If appropriate, refer the patient to other possible resources.

If a patient becomes verbally abusive or physically threatening, appropriate staff—the medical receptionist and the care coordinator should be alerted to assist in a supportive capacity. Staff members should be present on a standby basis and be prepared to intervene if required. For example, if the designated staff person becomes ineffective with the patient, another staff person should take over giving the same message.

People whose behavior escalates beyond communications will be asked to leave and be informed that it is not our policy to serve belligerent people. If they can remain calm and discuss the problem, however, we will attempt to serve them and work out a solution. If necessary, the medical receptionist and the care coordinator will escort them off the premises.

In extreme situations, the police will be called to intervene and staff will stop further involvement unless it becomes necessary to restrain a patient for his or her own safety or for the safety of the staff. In this situation, only designated, trained staff will perform the task of restraint. It is our goal to prevent escalation of a possible confrontation and to serve our patients.

In the event of a traumatic encounter, all staff members involved will meet to support each other through the debriefing process. They will document the encounter, file notations in the patient's chart, and determine if our services will be offered to the patient in the future. If the patient is denied further services, a letter stating this will be handed to him or her at the final encounter.

# **Wasatch Homeless Health Care Program Safety Manual**

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## **Purpose**

The purpose of this manual is to outline proper procedures for handling situations with aggressive patients that have the potential to further escalate into violence. Staff safety is our top priority at all times. It is also important to respond to aggressive or violent situations in a professional and sensitive manner. Our patients are individuals who deal with grave physical and emotional difficulties daily, and they should not be subjected to unnecessary suffering from interacting with clinic staff or volunteers.

## **Patient Stress and Special Extenuating Circumstances**

When serving our patients, it is important to keep in mind the extremely adverse living conditions and backgrounds patients come from. Stressful living situations break down morale and social behaviors such as courtesy and patience. Under these circumstances, it can be challenging to deal with such a person. If the patient is involved with drugs or alcohol, suffers from a mental illness, or has a serious antisocial background such as a history of criminal activity or prison, they can be especially difficult.

Another factor exacerbating a patient's frustration is the fact that many of them frequently interact with a multitude of private and public agencies to get basic needs met. Consequently, during the process of waiting, answering personal questions and applying for various types of assistance, their frustration level often becomes elevated. By the time that they visit our clinic, they may be—understandably—in the mood to react negatively towards our requests or instructions.

Although a patient's negative behavior may appear unwarranted, this behavior may be a learned survival technique. Through hard living, some patients have found that an aggressive, demanding behavior will get their needs met no matter how inappropriate.

In addition, there are individuals who blame the system for everything that has happened to them. These patients give up very easily using passive-aggressive behaviors—such as walking out—to express frustration. It is important to remember not to take a patient's negative or aggressive behavior personally. There are reasons for this behavior, and most likely you are not the reason.

Regardless of the patient's actions, it is imperative that staff reactions not encourage further negative behaviors or responses. Instead, we can employ simple intervention strategies when a patient begins to act inappropriately within the clinic environment.

### **Guidelines for Addressing Aggressive Patients**

Strategies for dealing with aggressive individuals are best formulated around the principle of least restrictive measure. This means starting with the least invasive tactic for subduing the aggressor and not advancing to the next level of restriction unless absolutely necessary. The three levels of intervention are:

- Level 1: Prevention;
- Level 2: De-escalation of tension; and
- Level 3: Action aimed toward safety for all individuals involved.

Our goal of preventing violent behavior can be achieved by effectively employing these four basic steps:

- n Observing,
- n Skilled Listening,
- n Talking, and
- n Actions.

### **LEVEL 1: PREVENTION**

The first and best method for managing physically or emotionally assaultive behavior is to anticipate and prevent. Management can be achieved by early assessment of the patient. For example, what are his or her needs? Can we meet these needs? If not, what options can we offer the patient, e.g., *"Would you like to speak to a supervisor?"* Consider whether there is another facility that can assist the patient and ask, *"Can we make a referral for you?"* or *"Would another time be more appropriate?"*

**Observation.** As you work, pay attention to the following warning signals that may hint of escalating tensions:

- n Defiant attitude
- n Excessive swearing
- n Aggressive motions
- n Unusual demands
- n Increase or decrease in voice volume
- n Challenging demeanor
- n Tightening of jaws
- n Deep sighs

- n Fidgety movements
- n Rapid pacing
- n Clenched fists
- n Advance or retreat actions

## **LEVEL 2: DE-ESCALATION OF TENSION**

**Listening.** The listening and attending skills of therapeutic communication are the most effective tools of averting violent behavior. Even though you may be having a busy, stressful day, remember to clear your mind and pay attention to what the other person is trying to tell you. Don't rehearse your response. Don't defend yourself verbally.

Practice reflective listening. This involves finding out information about what a person is thinking and feeling, and what may be done about a problem. Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer. Listen carefully to what is said. Spending two or three minutes interacting with the patient may prevent an altercation. The more information you have, the better you will be able to work out a solution.

### **Steps for Effective Listening**

- n Tune in to your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
- n Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say *"You seem very upset"* or *"I'm concerned that you might hurt yourself or others here."*
- n Try to elicit the real issue and determine what is behind the anger.
- n Demonstrate appropriate affect. Be sincere and assertive.
- n Convey calmness, control and a willingness to help.

**Talking.** Being able to talk down an angry, agitated patient is a valuable skill for anyone providing patient care services. It is a skill dependent upon having and demonstrating a positive regard and respect for others. While talking, be aware of your voice. The tone of your voice will have an immediate affect upon the patient. It is imperative that your voice remains calm and soft yet firm. If you become angry or aggressive like the patient, you will be giving away your control of the situation. Simply state the facts and if necessary, repeat them. Avoid using your title or authority. Do not offer lengthy explanations or excuses.

### **The Don'ts and Do's of Therapeutic, Effective Talking**

#### *The Don'ts — Verbal*

- n Don't threaten the patient or demand obedience.

- n Don't argue with the patient about the facts of the situation. Both of you may be right, but this does not help ease the situation.
- n Don't tell the patient that she or he has no reason to be angry.
- n Don't become defensive and insist that you are right.
- n Don't offer placating responses such as *"Everything will be OK"* or *"You're not the only one."*
- n Don't make promises you can't keep.
- n Never challenge the patient or call his or her bluff.
- n Never criticize the patient.
- n Never laugh at the patient.

#### *The Do's — Verbal*

- n Do ask, *"What can I do to help?"*
- n Do use simple, direct statements.
- n Do ask opinions: *"In what way do you feel we may be of service to you?"* or *"How would you like to see the situation resolved?"*
- n Do offer choices and alternatives: *"If our services are not appropriate, may we assist in referring you to another facility?"* or *"May we make another appointment for you at a more convenient time?"* Try to leave the patient with options.
- n Do encourage verbalization of anger rather than acting out. Express your limitation with this verbalization, however, such as expressions or language that is too offensive and not necessary.
- n Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner.
- n Do assume that the patient has a real concern and that she or he is understandably upset.
- n Do recognize and acknowledge the patient's right to her or his feelings.

### **LEVEL 3: ACTION**

**Taking Action.** Everything that we have learned so far about interacting with difficult patients becomes part of the process and culminates when we take action. A key concept in violence prevention is to try to decrease the person's sense of powerlessness or helplessness in order to minimize his or her frustrations. Communicate verbally and behaviorally that the person is responsible for his or her own actions. The following steps promote successful interactions:

#### **The Don'ts and Do's of Successful Interactions**

##### *The Don'ts — Actions*

- n Don't ignore the patient.

- n Don't come too close to the patient or hover over him or her. Keep a comfortable, nonthreatening distance between you and the patient that still allows you to hear and be heard.
- n Don't make threatening physical gestures.
- n Don't analyze or interpret the patient's motivation.
- n Don't personalize the patient's anger.

#### *The Do's — Actions*

- n Follow instinct and intuition. Use common sense.
- n Detect danger signals.
- n Keep everyone feeling safe:
  - q Open the door to the room;
  - q Identify an escape route convenient to you and the patient;
  - q Position yourself closest to the room exit;
  - q Keep furniture positioned with safety in mind; and
  - q Assess the environment for potential weapons.
- n Identify a code word that will alert the need for additional help. For example, clinic staff and volunteers are to say *Code Red* through the telephone intercom and identify the area where they are. At that point, designated staff are to respond.
- n Protect others in nearby surroundings.
- n Ask the patient to sit down.
- n Establish and maintain eye contact.
- n Observe social distance. Don't touch the patient.
- n Decrease environmental stimuli by:
  - q Minimizing the presence of staff and other patients,
  - q Turning down any loud music, and
  - q Minimizing distractions.
- n Promote privacy.
- n Attempt to meet as many of the patient's reasonable requests or demands as possible.
- n Follow through with promises. Do not make promises that you can't keep.
- n Remember who you are and practice professional behavior.

#### **Summary**

These principles, guidelines and procedures are basic suggestions to assist in averting abusive and violent behavior. They are for the express purpose of effectively serving our patients as well as protecting staff from dangerous and abusive behavior. When put into practice, these steps of observing, listening, talking and action can help achieve our goal of preventing violent behavior. Using common sense while practicing courtesy, concern and compassion will greatly enhance everyone's experience at our clinic.

Always keep in mind the adverse living conditions that our homeless patients deal with day and night. If we can be empathetic, and treat them as we would like to be treated, then we have not only provided good health care, but perhaps we have empowered them in their attempt to take control of their lives.



## **ACTIVITY 4 Creating An Outreach Worker Safety Plan**

Purpose: To identify specific suggestions for outreach workers and programs to ensure worker safety is promoted and addressed in the work environment

Time: 30-45 minutes

Materials: None

Preparation: Be familiar with the activity instructions below.

Procedure:

1. Form small groups of approximately four to six participants.
2. Each group is given the assignment to create a proposal for an outreach worker safety plan for their program or agency. This proposal is to identify some of the key elements to be included in the plan and some specific ways to address them. The proposal is to focus on prevention efforts vs. emergency responses. These ideas will be presented for consideration at an all-staff planning retreat.
3. Ask each group to take various perspectives into consideration as they form their plan. These might include:
  - Outreach workers representing various clinical backgrounds
  - Those doing site-based outreach and those doing outreach on the streets
  - Workers involved in outreach to various subpopulations, e.g. families, youth, persons with issues related to chemical dependency, mental health, HIV, domestic violence, etc.
  - Program supervisors, administrators, members of the Board of Directors
  - Homeless clients
4. Instruct each group to take about ten minutes, or more if needed, to generate as many ideas as they can that are aimed at promoting and sustaining awareness of safety for outreach workers. Urge them to think broadly and to include ideas related to program policies and procedures as well as to individual worker awareness and responsibilities. (See the handouts from Activities II and III to prompt some ideas.)
5. After this period of brainstorming, each group is given another ten minutes or so to create a presentation for the all staff retreat that highlights the top plans/activities from their worker safety plan. The following expectations apply to the presentation:
  - All members of the group are urged to participate in the presentation itself (unless they have a note from their mother!)
  - It is to be interesting and imaginative, not boring! (The use of skits, songs, limericks, haiku, games, role-plays, etc. is highly encouraged.)

- The presentation should include approximately 3-5 specific activities for implementation.
- The presentation should take no more than five minutes.

6. Have the small groups make their presentations to the retreat attendees. After each presentation, or after all have been completed, allow time for questions and comments from the audience.

7. Conclude the activity by discussing the most viable ideas that were raised and challenge participants to consider ways to promote and implement them in their own work settings.

## **ACTIVITY 5 Video: Nonviolent Crisis Intervention. Volume I: The Preventative Techniques**

Purpose: “Nonviolent Crisis Intervention” is a non-harmful behavior management system to aid staff in maintaining the best possible care and welfare of agitated or out of control individuals – even during their most violent moments. This video is designed to help staff develop preventative techniques necessary to defuse potentially violent situations. It also presents a philosophy of care and welfare, as well as safety and security for all who are involved in interventions.

Time: Running time 27 minutes

Materials:

TV/VCR

Copy of video: Nonviolent Crisis Intervention. Volume I: The Preventative Techniques. Produced by Crisis Prevention Institute, Brookfield, WI.

Preparation:

Borrow a copy of the video at no cost from the Health Care for the Homeless Information Resource Center at (888) 439-3300. Reservations must be made at least two weeks in advance.

Procedure:

1. Introduce the video and show it to the group.
2. Allow ample time for discussion afterwards including possible role-playing and practicing techniques.

(Alternatively, consider showing the video in segments with time between spent in discussion, role-playing and practicing techniques.)

## 2D: Cultural Competence in Outreach

"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework."

*T. Cross, et.al. 1989*

"Cultural competency is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each."

*Seattle King County Dept of Public Health, 1994*

"Cultural competence involves recognition and respect for differences among patients in terms of their values, expectations, and experiences with health care, while at the same time recognizing the culture-based practices and dictates of organized medicine, and the values, expectations, and experiences of the providers who practice it.

*The Cross Cultural Health Care Program*

*Cultural Competency Curriculum, 1999*

### **Purpose**

To promote the development of culturally competent practice in outreach

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

Below are some useful websites about culturally competency. You are encouraged to browse these sites for your own benefit and as preparation for the activities that follow in this section.

<b>Name of website</b>	<b>Description of website</b>
Diversity RX <a href="http://www.diversityrx.org">www.diversityrx.org</a>	The Diversity RX website provides facts about language and cultural diversity in the United States; offers an overview of models and strategies for overcoming cultural and linguistic barriers to health care; reviews federal, state and organizational policies and protocols; addresses legal issues; addresses research that has been performed in this area; and provides networking and resources. In addition, they sponsor conferences and offer training packages.
The Cross Cultural Health Care Program, Seattle WA <a href="http://www.xculture.org">www.xculture.org</a>	The Cross Cultural Health Care web site provides relevant information in the form of books and resources, training programs, interpreter services, translation services, and research programs.
The Center for Cross Cultural Health, Minneapolis, MN <a href="http://www.crosshealth.com">www.crosshealth.com</a>	The Center for Cross Cultural Health offers conferences, training, publications and additional links to other related websites.
National Center for Cultural Competence, Georgetown University Child Development Center <a href="http://gucdc.georgetown.edu.nccc/index.html">http://gucdc.georgetown.edu.nccc/index.html</a>	The National Center for Cultural Competence provides publications, a newsletter, policy briefs and additional links to related websites that are designed to assist in the design, implementation and evaluation of culturally competent service delivery systems.
The National MultiCultural Institute <a href="http://www.nmci.org">www.nmci.org</a>	The National MultiCultural Institute provides information on organizational training and consulting, conferences, publications and resource materials that include trainer manuals, books on cross-cultural mental health and videos.
The Provider's Guide to Quality and Culture <a href="http://erc.msh.org">http://erc.msh.org</a>	The Provider's Guide to Quality and Culture website provides an interactive quality and culture quiz; topics on quality and culture such as clinical outcomes, common health problems in selected minority, ethnic and cultural groups, common beliefs and cultural practices, relating to patient's families, culturally competent organizations; working with an interpreter; book excerpts; and additional resources.

<p>EthnoMed, Harborview Medical Center, Seattle WA  <a href="http://www.ethnomed.org">www.ethnomed.org</a></p>	<p>The EthnoMed site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants, many of whom are refugees fleeing war-torn parts of the world. This site contains profiles of a variety of ethnic groups, including Hispanics/Latinos as well as patient education materials in a variety of languages.</p>
<p>The National Alliance for Hispanic Health, Washington DC  <a href="http://www.hispanichealth.org">www.hispanichealth.org</a></p>	<p>The National Alliance for Hispanic Health website provides information about Hispanic health issues, patient education materials in English and Spanish, and has a newsletter.</p>

Compiled by Jen Holzwarth, Training Specialist, National HCH Council

## **ACTIVITY 1 Diversity Eye-opener**

Purpose: To help participants connect issues of diversity and cultural competency with their own experience

Time: 20-25 minutes

Materials: None

Preparation:

Review the activity as described below. This is a relatively "safe" eye-opener for participants to help connect issues of diversity and cultural competency with their own experiences.

Procedure:

1. Ask participants to form pairs or small groups to identify and discuss the following questions:
  - a) Where did you grow up?
  - b) What other cultural groups and practices did you encounter – ethnic, race, class, sexual orientation, religious, etc.?
  - c) What messages were you given about people who were different – messages from family, from peers, from the media, and others?
  - d) How have your background experiences influenced your perceptions of other "cultures" that you encounter in your outreach work?
  
2. Reconvene as a large group and ask participants to think about a time when they experienced being or feeling "different" in a group of people – for example, from an ethnic, gender, class, political, religious, or other perspective. Then ask them to identify and share with the group what others did that helped or hindered them to feel more welcomed.
  
3. Summarize the helpful and the less than helpful strategies one might use when interacting with someone who is "different" in a given situation.

(Thanks to Jackie Green, diversity consultant from St. Louis, for the ideas from which this exercise is adapted.)

## **ACTIVITY 2 Understanding the “Culture” of Extreme Poverty**

Purpose: To gain a clearer understanding of the cultural issue that cuts across every encounter with homeless people – what it means to live in extreme poverty

Time: 20 minutes

Materials: Flipchart and markers

### Preparation:

There are myriad cultural differences workers will encounter in outreach. Perhaps the most fundamental of these is what it means to live in a “culture” of extreme poverty, of which homelessness is a manifestation. Many of us are culturally ignorant about living in poverty of any kind. Workers need to understand that the needs, the preoccupations, the barriers, the “rules of living” are often different when one has little or no money, resources, or social support.

This activity attempts to have participants walk in the shoes, if only for a few moments, of people living under the conditions of extreme poverty and thus increase our cultural understanding. This activity has commonality with activities in Module I “The Realities and Experience of Homelessness.” It is suggested that you review that section in the curriculum as preparation for this particular activity.

### Procedure:

1. Ask participants to take a few moments in silence to put themselves in the place of living under the following circumstances – wandering the streets in a bustling city, with no money, begging for food, seeking a place to urinate, inadequately dressed for the weather, in ill health, belonging to the poorest class/caste of society, etc. Acknowledge that this can be very difficult to do. Many of us need to keep a safe distance in our minds from even imagining ourselves in this situation.

2. After a brief period of silence, ask the group to think about and discuss the cultural differences between living in impoverishment and their own day-to-day existence. What “cultural” characteristics might result from living in extreme poverty that are different from your own (assuming you have adequate resources?) Urge participants to give specific examples in order to make it as real as possible. Some possible concepts to explore:

- the experience and use of time
- personal vs. public space
- weighing priorities between survival needs and other personal needs
- identity
- reputation
- friendship
- sexual and other intimacy needs
- sense of belonging
- leisure/play



- concept of stability
- trust
- loss
- hope
- notion of "personal growth"
- planning for the future
- etc.

## **ACTIVITY 3 Becoming Culturally Competent Outreach Workers**

Purpose: To define cultural competence and describe its key elements

Time: 25-30 minutes

Materials:

Handout: "Seven Domains of Cultural Competence"

Handout: "Becoming Culturally Competent Outreach Workers"

Preparation:

Every outreach encounter is cross-cultural, if for no other reason than the extreme poverty under which homeless people live. Often times the cross-cultural nature of these encounters cuts across many other axes in addition to economic and social class. In order to provide appropriate, compassionate, and effective outreach services, workers need to be attuned to the cultural differences and similarities that exist between they and their clients. It is hoped that the worker will celebrate the gifts that both difference and likeness brings, and will likewise work to overcome barriers to relationship and care that these cultural differences may sometimes represent.

In preparation for this activity, review the various definitions of cultural competence provided at the beginning of this section and read the statements below. In addition, read and reflect on the two handouts for this activity.

"Cultural competence begins with an honest desire not to allow biases to keep us from treating every individual with respect. It requires an honest assessment of our positive and negative assumptions about others. This is not easy — no one wants to admit that they suffer from cultural ignorance, or in the worst case, harbor negative stereotypes and prejudices. Learning to evaluate our own level of cultural competency must be part of our ongoing effort to provide better health care."

*(Provider's Guide to Quality and Culture <http://erc.msh.org/quality&culture>)*

"One of the dangers in writing a guide to culture is that in trying to describe an entire cultural group, a guide may create or reinforce stereotypes. It is important to remember that diversity exists in every group of humans. In addition, people change through acculturation and assimilation. We also must avoid jumping to conclusions. If a person wears traditional ethnic dress this may not mean that they lack English language skills; or if a woman wears traditional clothing, one cannot assume that she does not work outside the home. And the converse may be true of someone wearing typical western clothing. We have to evaluate each person using a number of cultural clues, and when in doubt, learn to ask questions in a culturally sensitive fashion. We also have to be ready to reevaluate each individual as they undergo change."

*(Hassoun, Rosina "Preface on Medical Anthropology: Anthropological Medicine" Guide to Arab Culture: Health Care Delivery to the Arab American Community Authors: 1999)*

### Procedure:

1. Read aloud and discuss the definitions of cultural competence at the beginning of this section.

2. Go over the material in the handouts beginning with the "Seven Domains of Cultural Competence" followed by "Becoming Culturally Competent Outreach Workers." As you review various topics, raise questions that invite discussion. Below are several suggested questions to pursue:

- What are the seven domains of culturally competent practice? Can you give some specific illustrations for each domain from your perspective as an outreach worker?
- What are some of your "personal attitudes, beliefs, biases, and behaviors" that are likely to have a positive influence on your outreach?
- What are some possible "barriers to care" that you sometimes see in yourself, i.e. your own attitudes and actions, in addition to client, community and systems barriers?
- How would you define "cultural humility"?
- What is it about a "client-centered" approach that makes your outreach more likely to be culturally competent?
- What are some ways you can challenge various forms of prejudice and discrimination in your workplace? In your outreach work?

3. To conclude the activity, invite participants to consider taking a concrete "next step" on their journeys towards cultural competence. Suggest that they do this by choosing one of the seven domains on which they want to focus and then identifying a specific activity relevant to that domain to implement in the very near future. Have participants share some of their ideas. Below are a few suggestions as examples:

- Carefully read your agency's policies about cultural competence (assuming they exist)
- Read and learn more about the history and culture of a specific ethnic group to which one of your clients belongs
- Scrutinize your office, workspace, or your agency's public space for its "cultural and linguistic friendliness" (e.g. signage, posters, brochures, artwork, etc.) and/or bring up the topic in a staff meeting
- Have a frank conversation with a trusted colleague or friend for the purpose of doing a "self-check" about your own cultural sensitivity. Ask them to give you specific feedback and suggestions.
- Other

# Seven Domains of Cultural Competence

## 1. Values and attitudes

Promoting mutual respect . . . awareness of the varying degrees of acculturation . . . a client-centered perspective . . . acceptance that beliefs may influence a patient's response to health, illness, disease and death

## 2. Communication styles

Sensitivity . . awareness . . . knowledge . . . alternatives to written communication

## 3. Community/consumer participation

Continuous, active involvement of community leaders and members . . . involved participants are invested participants, health outcomes improve

## 4. Physical environment, materials, resources

Culturally and linguistically friendly interior design, pictures, posters, and artwork as well as magazines, brochures, audio, videos, films. . . literacy sensitive print information . . . congruent with the culture and the language

## 5. Policies and procedures

Written policies, procedures, mission statements, goals, objectives incorporating linguistic and cultural principles . . . clinical protocols, orientation, community involvement, outreach. . . multicultural and multilingual staff reflecting the community

## 6. Population-based clinical practice

Culturally skilled clinicians avoid misapplication of scientific knowledge . . . avoid stereotyping while appreciating the importance of culture . . . know their own world views . . . learn about populations . . . understand sociopolitical influences . . . practice appropriate intervention skills and strategies

## 7. Training and professional development

Requiring training . . . nature of cultural competence training . . duration and frequency of professional development opportunities

From "Cultural Competence: A Journey" (<http://bphc.hrsa.gov/culturalcompetence>)

# Becoming Culturally Competent Outreach Workers

## *Reminders on the journey ...*

- We need to **“check our own pulse”** and become aware of personal attitudes, beliefs, biases, and behaviors that may influence (consciously or unconsciously) our outreach activities as well as our interactions with colleagues and staff from diverse racial, ethnic, and sociocultural backgrounds.
- **Every outreach encounter is cross-cultural.** Developing partnerships with people experiencing homelessness and maintaining “cultural humility” can help us to learn and better understand the social and environmental contexts in they live.
- **There is no “one” way** to treat any racial and ethnic group, given the great sociocultural diversity within these broad classifications. We need instead to have a framework of interventions that can be individualized and applied in a client-centered manner.
- Our outreach work needs to be **flexible, authentic, and ethical.** We need to appropriately tailor our interventions to our clients and their situation.
- **Diversity is often greater within groups than between them.** Cookbook approaches about working with patients from diverse sociocultural backgrounds are not useful and instead risk potentially dangerous stereotyping and overgeneralization.
- It is important to understand not only **client and community barriers to care, but outreach worker and social/health care system barriers to care.** To eliminate racial and ethnic disparity, health care providers and organizations need to become more culturally and linguistically competent.
- We need to challenge and confront **racism, sexism, classism, and other forms of prejudice and discrimination** that occur in outreach encounters as well as in the society-at-large.

(Adapted from Betancourt, J. R., and R. C. Like. 2000. “Editorial: A New Framework of Care.” *Patient Care* Special Issue, Caring for Diverse Populations: Breaking Down Barriers, May 15, 2000, pp. 10-12.)

## Activity 4 Provider's Guide to Quality and Culture – Take the Quiz

Purpose: 1) To test your own personal knowledge about quality health care and culture via a self-quiz, and 2) To explore issues relevant to cultural competence for health care providers through an interactive web-based medium

Time: 10 minutes to complete the on-line quiz – considerably more time can be spent reading related materials on this site and its links

Materials: Personal computer with Internet access

Preparation: Go to *The Provider's Guide to Quality and Culture* website at <http://erc.msh.org/quality&culture>. Take the quiz and take time to browse the site thoroughly.

Procedure:

1. Introduce participants to this web site. Ask them to take the quiz as “homework” or onsite during the class if you have computers available with Internet access. Below is the introduction section from the website.

“Health care professionals looking for a way to provide culturally and linguistically appropriate services to multicultural populations can now use a new Web-based tool supported by The Health Resources and Services Administration (HRSA).

*The Provider's Guide to Quality and Culture* features an interactive quiz that helps users enhance their knowledge and skills. The guide also has 11 modules on topics such as common health problems in selected minority, ethnic and cultural groups, and understanding immigrant, refugee and minority populations. Each module contains readings, mnemonics, exercises, references and annotated links to other relevant Web resources.

The *Provider's Guide* was developed by Management Sciences for Health, a nonprofit organization dedicated to the improvement of global health. In the near future, MSH intends to expand the interactivity of this site to include computer-assisted approaches to build a virtual learning community of experts and practitioners of culturally and linguistically competent health care.

The *Provider's Guide* is a ‘work in progress’ that will be periodically updated. Comments and suggestions are encouraged. Contact information is listed on the first page of the Web site.”

2. If possible, discuss with participants what questions and insights arose for them as a result of visiting this interactive site.

## **Activity 5 Cultural Competence: A Journey**

Purpose: To learn about cultural competence in the provision of health care for underserved and unserved populations. This is a self-guided exercise for individual participants.

Time: 30 minutes

Materials: Personal computer with Internet access

Preparation: Go to <http://bphc.hrsa.gov/culturalcompetence/Default.htm> on the Internet and do the self-guided exercise, Cultural Competence: A Journey. As you do so, reflect on your own place on the "journey."

### Procedure:

1. Request that participants go to the **Cultural Competence: A Journey** website and do the self-guided exercise there.
2. Encourage them to take time to carefully read through the materials presented. This is a web site produced for the Bureau of Primary Health Care that provides an excellent overview of the main themes of cultural competence and is sprinkled with numerous case examples of the provision of culturally competent health care to underserved or unserved populations. It also has some very nice graphics. The themes presented in this site are directly relevant to the work of HCH outreach workers.
3. After participants have visited the site, invite them to discuss what insights they have discovered on this "self-guided cultural competence journey."

## Activity 6 The Spirit Catches You and You Fall Down

Purpose: To experience the “collision of two cultures” in health care in a widely acclaimed book by Anne Fadiman published in 1997

Time: Variable, depending on reading pace

Materials: A copy of *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. By Anne Fadiman. New York, NY: Farrar, Straus, and Giroux, 1997. Winner of the National Book Critics Circle Award.

### Preparation:

Read the book for yourself if possible, or read various reviews about it on the Internet. Also, go to <http://www.fsbassociates.com/fsg/spiritrg.html> for an excellent reader's guide that poses twenty-one questions and subjects for discussion. An example question: “When polled, Hmong refugees in America stated that difficulty with American agencies was a more serious problem than either war memories or separation from family. Why do you think they felt this way? Could this have been prevented? If so, how? What does the author believe?”

### Procedure:

1. Introduce the book The Spirit Catches You and You Fall Down. Inquire if anyone has read it who might want to share his or her impressions. This book speaks very directly to issues related to cultural competence in a health care context. Encourage participants to read the book individually or perhaps in study groups. Refer them to the study guide at <http://www.fsbassociates.com/fsg/spiritrg.html>. Read the book jacket description below to the group.

“This moving chronicle of a very sick girl, her refugee parents, and the doctors who struggled desperately to treat her, becomes, in Anne Fadiman's deft narrative, at once a cautionary study of the limits of Western medicine and a parable for the modern immigrant experience.

Lia Lee was born in the San Joaquin valley in California to Hmong refugees. At the age of three months, she first showed signs of having what the Hmong know as *qaug dab peg* (the spirit catches you and you fall down), the condition known in the West as epilepsy. While her highly competent doctors saw the best treatment in a dizzying array of pills, her parents preferred a combination of Western medicine and folk remedies designed to coax her wandering soul back to her body.

Over the next four years, profound cultural differences and linguistic miscommunication would exacerbate the rift between Lia's loving parents and her caring and well-intentioned doctors, eventually resulting in the loss of all her higher brain functions. Fadiman weaves this personal tragedy, a probing medical investigation, and a fascinating look at Hmong history and culture into a stunningly insightful, richly rewarding piece of modern reportage.”



# **Module 3: APPROACH**

## **BUILDING THE BOND OF TRUST**

### **Purpose**

The purpose of Module 3 is to increase participants' knowledge and skills in making observations, preparing an introduction, building trusting relationships, and putting into practice the fundamentally important skills of listening in outreach and engagement with people experiencing homelessness.

## **3A: Observation and Making an Introduction**

### **Purpose**

To increase participants' knowledge and skills in making initial observations and in preparing an introduction in the Approach phase of outreach

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## ACTIVITY 1 Observation From “Fifty Feet”

Purpose: To sharpen the outreach worker’s observation skills prior to making an introduction

Time: 20-25 minutes

Materials:

Handout: Approach

Resource Paper: Relational Outreach and Engagement Model

Preparation: Whenever possible, outreach workers are wise to size up a situation before making an approach. This is valuable for making a general assessment of the homeless person’s condition and circumstances, and for deciding how to make an introduction. It is also important for safety reasons. If the worker observes that someone is sleeping, is agitated, is having trouble breathing, is obviously paranoid, or is under the influence, the approach to each will be different. In addition, the worker’s approach will depend on what is going on in the surrounding environment. For example, if there is a lot of commotion or a drug deal appears to be going down, an approach should wait for another time.

Prepare for this exercise by reviewing the handout and the section on “approach” in the resource paper. In addition, reflect on your own experience in outreach. Note that these observational skills are important to practice prior to every outreach encounter, not just when making an initial contact. They are part of ongoing assessment activities.

Procedure:

1. Drawing upon the comments above in the Preparation section and from your own experience, explain the reasons for making careful observations prior to making an introduction to a homeless person.
2. Distribute the Approach handout. Review the “observational fields” that are listed (e.g. setting and situation, appearance, belongings, etc.). Include other fields as is appropriate, particularly those that might apply to a particular target population.
3. Go back over each “observational field” and invite participants to come up with some specific observations, in addition to the examples noted on the handout, that they might make in doing outreach. Furthermore, ask what kinds of assessment questions certain observations might raise in the “back of participants’ minds.” For example:
  - You observe the individual is quite disheveled and wearing multiple layers of tattered clothing. Possible questions? *What are the likely reasons the person is dressed in this manner? Is the individual aware of available*

- clothing/hygiene resources? Is the reason possibly related to mental illness or a substance use disorder? What health risks might this pose?*
- You observe someone sitting on a bench near the bus station in inclement weather with a heavy backpack by his/her side. Possible questions? *Is the person homeless? Perhaps newly arrived in town? Do they need assistance to get protection from the weather? Need other resources?*
  - You observe that a person walking down the sidewalk is acting in a very intrusive manner. Possible questions? *Is this individual angry about something? Experiencing mania or some other psychotic symptoms? Under the influence of alcohol or drugs? Exhibiting typical behavior given his/her personality?*
  - And so forth ...

# APPROACH

## Observation From "Fifty Feet"

Careful observation yields basic assessment information about the individual and their surroundings and helps to determine how to make an introduction.

Setting and situation    calm, safe, open ... chaotic, dangerous, closed in

Appearance    clean, suitably dressed ... dirty, disheveled, ill-clothed

Belongings    e.g. walking cane, wheelchair, dog, backpack, two shopping carts filled with garbage bags

General health status    appears healthy ... open sores, unsteady gait

Behavior    predictable, appropriate to context ... avoidant, agitated, bizarre

Social interactions    interactive, pleasant ... very guarded, interruptive

Basic needs    none apparent ... needs warm coat, socks, food, shelter

## Making An Introduction

The key is to present in general as a person who cares and is willing to "meet the individual where they're at." Thereafter, one's role and affiliations are defined more specifically as trust is built and the relationship develops. Below are some "identities" with which workers might introduce themselves.

Physical "presence" (little if any verbal contact)

Fellow human being

Neighbor

Concerned citizen

Outreach worker

Health/mental health/chemical dependency specialist

(Adapted from unpublished papers by Craig Rennebohm)

# Relational Outreach and Engagement Model

Adapted from unpublished papers by  
Craig Rennebohm, Mental Health Chaplaincy

The **Relational Outreach and Engagement Model (ROEM)** provides a theoretical framework for understanding the outreach and engagement process, offers specific practices appropriate to each stage of the work and suggests benchmarks by which movement along the outreach and engagement continuum of care can be assessed. In the ROEM view, life has a profoundly relational character. The implication for outreach is not whether one can establish a relationship with another, but rather how will any given relationship develop and take shape from moment to moment over time.

For teaching purposes the outreach and engagement process is envisioned in four phases: **approach, companionship, partnership and mutuality**. Each phase is marked by a predominant quality in the emerging relationship as seen from the perspective of the outreach worker and the experience of the homeless individual. The model is a theoretical ideal. It is not intended to suggest that the outreach and engagement process flows in a neat linear progression or that the four phases are discrete, clearly bounded stages.

In practice the relational field in which the outreach worker and the homeless person move is extraordinarily complex and filled with many subtleties and unknowns. Outreach is necessary precisely because the more general and generic processes by which people come into care (referral, appointment, walk-in, screening, intake etc.) have not proven successful in leading to treatment.

Outreach and engagement practice seeks to build a relationship of trust and care with those who present unusual challenges and are the most difficult to serve. The process can take days, weeks, months, even years. The outreach worker must be present in a variety of ways with the individual, in brief moments and over long hours, on an unpredictable schedule, as the person is ready. While this model has a certain simplicity and elegance, it is an abstraction from the many earthy, involved steps which lead from the street to stability.

The Relational Outreach and Engagement Model provides an orientation to the challenges before us. It is a reminder, in the midst of the difficulties of practice, that we are involved in a complex but ultimately hopeful process.

Isolation and distance characterize the relational field of the homeless individual without care. The individual has few and minimal interactions with others. In the **approach** phase the outreach worker honors the tentativeness of the relationship. This phase is marked by the intention of the outreach worker to be present, and to weave, if possible, a fabric of connection, thread by precious thread. Meetings are random, spontaneous, loosely planned. Visits are brief, with

little or no agenda. The role of the outreach worker is at its most diffuse -- neighbor, a caring observer, a passerby willing to stop and listen.

In the approach phase, specific activities are minimal -- a smile, a nod, an inquiry, a brief offer to help, a cup of coffee placed beside the person. No one thing and many little things embody the outreach intention. The worker waits carefully for the smallest sign, the slightest hint of a response. No one moment suggests that we are making progress. There are setbacks, pauses. These too are part of the process. Our occasional notes reflect the tenuous nature of the work. "Saw John at Westlake Park, said hello." A week or two or more of no contact. Another brief encounter.

The transition from the approach to **companionship** phase occurs as the outreach worker offers and is permitted to share the subject's journey. The worker is recognized, greeted, welcomed. In this phase the outreach worker is experienced as an increasingly trustworthy and established dimension of the person's life in the world, something of an anchor point if you will.

In the companionship phase the outreach worker provides a reliable presence, listens to the person's story, offers empathy and acts with knowledge and proper timing and in response to the individual's issues and concerns. The worker is attuned to the individual's current situation, how they see themselves, their perceptions of the world around them, and their ability to meet needs for care, safety and survival in the midst of homelessness. Personal strengths as well as deficits are noted. The presence of a physical, mental and/or substance abuse disorder might be observed and assessed.

Benchmarks of companionship include time spent walking or riding together, agreement on a regular meeting place and sharing hospitality moments such as a cup of coffee or a meal together. It may include a small task shared, help with some necessity, going together to check out a resource such as a drop-in center or shelter, or any of a hundred activities. No one instance determines the beginning of the companionship phase. A series, an accumulation of occasions together suggests the shift from approach to companionship is being accomplished. The dyad is growing stronger.

In the course of companionship there are increasing opportunities to introduce the homeless person to others who can assist in the journey from the street to stability. Key to the transition from companionship to **partnership** is the capacity of the outreach worker and the individual to open their relationship of trust to include a significant third party - a social worker, case manager, nurse, doctor or counselor who offers specific support for the person. The partnership phase is marked by the individual's acceptance of a growing circle of care in which the triad of subject, outreach worker, and a primary care provider form the core. The outreach worker's companionship role continues to be critical in this phase to

provide a trustworthy presence, information, and encouragement to the homeless person who is connecting with other providers and services.

The outreach and engagement process is completed as the worker and subject move into a phase of increasing **mutuality**. It is precisely the growing, common human bonds which the worker and individual share which permits the relationship to be brought to fruition and eventually to an appropriate termination. The worker celebrates with the individual such basic experiences as making a home, developing a daily routine, discovering arenas of work and recreation. In this context of a real and growing life with others, the worker prepares for separation and the transition into ongoing journeys along clearly differentiated paths.

In a relational model, outreach and engagement begins with an approach to the homeless person based on an affirmation of our common humanity and the possibility and potential for relationship. At the heart of companionship is a trustworthy dyadic relationship. In partnership a triadic relationship emerges at the core of the process. The final phase of the relationship is marked by the multiplicity of relationships, a sense of neighborhood and community in which the subject has a healthy sense of self and place.



## ACTIVITY 2 Ineffective Outreach Lines

Purpose: To explore how to make an effective introduction in outreach by playfully looking at less-than-helpful introductory lines

Time: 15 minutes

Materials: Paper and pen

Preparation:

Gather some prizes for the most ineffective outreach lines.

To prepare for the group discussion at the end of this activity, read the Preparation section in Activity III below for some thoughts about how to make an effective introduction.

Procedure:

1. Ask participants to write on a blank piece of paper three or more of the most ineffective outreach lines they can imagine. Tell them prizes will be given for the most creative and amusing lines.

If participants need some ideas to prompt them, here are a few suggestions:

- “Breath mint?”
- “I’m here to help. Trust me!”
- “Can you name the presidents from Eisenhower to the present?”
- “I’ll give you a dollar to sign this voluntary consent.”
- “You think *you’ve* got problems ...”
- “How can you do that to yourself? I faint at the sight of needles.”
- “I know *exactly* what you’re going through.”

2. Next have everyone meander around the room “trying” out their lines on others in the room ... and listening to other’s lines as well.

3. After a few minutes, bring the group back together and have them identify the “best” lines that they heard. Give out prizes for the best lines in various categories such as: most humorous, most creative, most bizarre, most insensitive, etc.

4. Take some time to discuss the qualities of effective vs. ineffective introductions in outreach and ask participants to come up with examples and make comments about effective approaches they have used to introduce themselves. Some possible questions to prompt discussion:

- *How do you generally introduce yourself in outreach? Why?*
- *What principles of outreach inform the way you introduce yourself?*
- *What different cues from homeless people themselves help you determine your introduction approach?*

## **ACTIVITY 3 Making an Introduction**

Purpose: To sensitize outreach workers to the importance of making a careful introduction that seeks common ground

Time: 15 minutes

Materials:

Handout: Approach

Resource Paper: Relational Outreach and Engagement Model

(Both of these materials can be found under Activity 1 in this section.)

Preparation:

Once outreach workers have made their observations “from fifty feet”, thus gathering basic information about the homeless individual and their surroundings, the next step is to make an introduction. This is not done lightly nor should it be done with a “one size fits all” approach. Particularly with individuals who are quite isolated and take pains to distance themselves from others, the worker must determine how to initiate contact in a way that “honors the tentativeness of the relationship” (Craig Rennebohm). This occurs best when we initially seek to find common ground, instead of offering help.

Each of us wears various “hats” in how we relate to people experiencing homelessness. These go from the general (fellow human being, neighbor, concerned citizen) to the more specific (outreach worker, health/mental health/chemical dependency specialist with the HCH program).

Often it is most useful to start with a general introduction, for example, “I’ve noticed you sitting here and just wanted to introduce myself and say hello.” Simply presenting as someone who is interested and cares is likely to be perceived as welcoming and non-threatening. Jumping too quickly to introducing oneself in a specific role or with a specific purpose (“I’m a mental health outreach worker who helps mentally ill homeless people access services”) can be an impediment to engagement for obvious reasons.

It is tempting to introduce oneself with an offer of assistance, but this presumption that someone needs or wants our help can be distancing instead of engaging. It immediately sets up a “helper – one who needs help” paradigm. Instead, when we meet another as “human being to human being” we minimize the power differential that is otherwise inherent in these relationships. It is useful to remember that an initial primary goal of introduction is to seek common ground.

Procedure:

1. Based comments in the Preparation section above, the resource paper, and your own outreach experience, talk with the group about the importance of

introducing oneself “mindfully” in outreach. Emphasize the notion of presenting oneself initially as someone who cares and is willing to “meet the person where they’re at” as a way of seeking common ground.

2. Review the various “identities” listed at the bottom of the handout that the worker might assume when making an introduction. Encourage the group to think of others as well.

3. Discuss various situations in which it would be important to be very general initially. In what circumstances might it be advantageous to be quite specific?

## 3B: Engaging and Connecting

“We work in an environment where trust is  
as fragile as an African violet”

– Abron Morgan, HCH outreach worker

### **Purpose**

To help outreach workers gain deeper self-knowledge and improved skills in building trusting relationships with people experiencing homelessness

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 Common Human Needs**

Purpose: To develop a deeper appreciation for the common needs we share as human beings and that form the value base for outreach work.

Time: 15-20 minutes

Materials: Handout: Common Human Needs: The Value Base for Outreach

Preparation: Review the seven common human needs as noted in the handout. Reflect on examples from your own life experience when each of these needs has been well met and times they have not. What were those experiences like? How did they affect the level of trust in the relationship?

Procedure:

1. Distribute the handout and ask participants to reflect on each of the common psychosocial human needs identified on the handout and think of examples from their own life experience when each of these needs has been well met and times they have not. What were those experiences like? How did they affect the level of trust in the relationship? Invite participants to share examples with the group.
2. Next, ask participants to individually rank these needs from highest to lowest importance for themselves. This ranking exercise is rather arbitrary and can create difficult choices. However, it does reveal something about oneself and the relative value a person places on these human needs.
3. Invite participants to share in small groups or the large group about their rankings and how they arrived at them. Note the differing perspectives and values that various individuals place on these common human needs.
4. Facilitate a large group discussion about how a worker's appreciation for each of these human needs might have a practical impact on one's outreach encounters with people experiencing homelessness. For example, a worker might become more proactive in inviting clients to express their feelings, or might acknowledge the need for personal secrets by asking clients to share only what they feel comfortable sharing. Also, emphasize that being responsive to these fundamental needs is directly related to building trust.

# **Common Human Needs: The Value Base for Outreach**

## ***Seven Human Needs***

- To be treated as an individual
- To express feelings
- To get sympathetic responses to problems
- To be recognized as a person of worth
- To not be judged
- To make one's own choices and decisions
- To keep secrets about oneself

Source: Biestek, F.P. *The Casework Relationship*, 1957.

## ACTIVITY 2 Three Tales of Engagement

Purpose: To develop an expanded understanding of effective outreach and engagement through the use of illustrative stories

Time: 25-30 minutes

Materials:

Handout: The Story of Edward Moore

Handout: The Land of Fools

Handout: The Little Prince

Preparation: Read the three stories in advance and prepare to facilitate a brief discussion about each based on the questions posed in the activity procedure below.

Procedure:

1. Explain that in this activity participants will hopefully expand their understanding about effective engaging and connecting strategies through the use of stories.
2. Begin by stating you want to provide an historical perspective to outreach and engagement, in this case, from Seattle in the 1850's. Read aloud The Story of Edward Moore including the introductory paragraph in italics. This story of course is pretty much about all the *wrong* ways to do outreach and engagement. Have the group identify from this story the various ways *how not to do provide outreach and engagement services!*
3. Next, have someone read aloud the Chinese folk tale called The Land of Fools. Follow up by asking for examples of how the outreach approaches as illustrated by the two strangers in the story might "translate" to real life outreach encounters.
4. The third story is an excerpted dialogue from The Little Prince. Ask for three volunteers to do a little reader's theatre. You'll need someone for the roles of the Reader, the Prince, and the Fox. Stage the reading at the front of the room and encourage the actors to "get into" their roles. After the reading, ask what the story tell us about some of the aspects required for "taming" the fox (e.g. initially keeping at a safe distance, being careful with words, meeting basic needs such as feeding, keep coming back on a predictable schedule, etc.) Also, inquire what the fox means when he says, "words often confuse things."

# The Story of Edward Moore

*This excerpt from the book Skid Road: An Informal Portrait of Seattle (1982:34-35) by Murray Morgan recounts the "outreach and engagement" efforts by the town's early settlers towards the unfortunate Edward Moore, Seattle's probable first homeless mentally ill resident. This story would be best categorized as a "how not to" example of doing outreach and engagement! The term "skid road" is said to have originated in Seattle, referring to Yesler Avenue, on which logs were skidded down the hill to Henry Yesler's sawmill on the waterfront in what is now called Pioneer Square. To this day, many of Seattle's homeless people and services are located in this area.*

Things were so; bad, cash-wise, that it is hard to guess how the community came to realize that one of its members, Edward Moore, was a pauper. Perhaps the determining factor was, in the words of Maynard's report, that Moore was "a stranger, and insane besides."

In a pioneer community like Seattle nobody knew what to do with an insane pauper. Finally Maynard offered to look after him if the county would pay his board bills. Maynard should have known better: King County had so little money that it was unable even to supply him with an official seal for his notary work. He kept the poor fellow for several months but, realizing that he would never get paid for it, at last turned him over to Dr. M. P. Burns of Steilacoom, who gave him a receipt for "an insane and crippled man, a stranger without acquaintance or friends."

Burns agreed to look after Moore until the Territorial Legislature took action on the subject of relief; he presented a bill for \$621 to the legislature for "custody and care of a non-resident lunatic pauper"; but the legislators, establishing a tradition, couldn't agree as to the need and didn't vote a cent.

Dr. Burns loaded his patient into a canoe, paddled him back to Seattle, and left him. Maynard didn't want him again; nobody did. The county commissioners decided that "Edward Moore, the pauper, now in Seattle, be sold at public auction to the lowest bidder for his maintenance to be paid out of the county treasury, said bid to be left discretionary with the Commissioners to accept or reject, on Saturday, the 7th day of June, at 2 o'clock in the town of Seattle."

Moore disappears from the official records with that. Apparently there were no bidders; at least no bid was accepted, and the insane man was left to wander the streets. At last the townsfolk took decisive action. They caught Moore, amputated his toes, which had been frozen, cleaned him thoroughly, put new clothes on him, and paid his passage on a ship bound for Massachusetts.



## **The Land of Fools**

*This Chinese folk tale illustrates the value of starting “where the person is” and moving ahead with a deliberate pace in our outreach and engagement work.*

Once a man strayed into the world known as the Land of Fools where he saw a number of people fleeing in terror from a field where they had been trying to harvest wheat. “There is a monster in that field,” they told him. Upon close examination the man saw that it was a watermelon.

The stranger offered to kill the monster for them. He walked into the field, cut the melon from its stalk, took a slice and began to eat it. Now the people were more terrified of him than they had been of the melon. They drove him away with pitchforks crying, “He will kill us next, unless we get rid of him.”

Years later a second man strayed into the Land of Fools and the same thing happened to him. But, instead of offering to help them with the monster, he agreed with them that it must be dangerous, and by tiptoeing away from it with them he gained their confidence. He spent a long time with them in their houses until he could teach them, little by little, the basic facts which would enable them not only to lose their fear of melons, but even to cultivate them.

# The Little Prince

**Reader:** There is this little prince who comes from a small planet and visits the planet Earth. The prince is lonely and wants a friend. He sees a fox.

**Prince:** Will you be my friend?

**Fox:** Me? I am a fox. You have to tame me first.

**Prince:** What does "tame" mean?

**Fox:** It means "to establish ties." It means then you are not just any little boy and I am not just any fox, but we are unique to each other.

**Reader:** Now the fox is *very lonely*. He thinks ...

**Fox:** I want this nice prince as my friend.

**Fox:** (to the Prince) Little Prince, please tame me.

**Prince:** How can I tame you?

**Fox:** First, you look at me out of the corner of your eyes from a distance, so you don't frighten me. You don't say anything. Words often confuse things.

**Prince:** Yes. Then what do I do?

**Fox:** Well, you come at the same time every day to feed me. You let me know ahead of time, because half the joy is in the anticipation.

**Prince:** I think I can do that. Then what?

**Fox:** Then, one day, you will tame me, and we will be friends.

Adapted from *The Little Prince* by Antoine de Saint-Exupéry Thanks to M. Elizabeth Fuhr for presenting this story as a model for outreach and engagement.

## **ACTIVITY 3 What is Your Relational Style?**

Purpose: To help outreach workers better understand their own personality patterns and relating styles and how these influence their efforts to engage and connect with people experiencing homelessness

Time: 30 minutes

Materials: Personal computer and Internet access

### Preparation:

Plan to facilitate a general discussion with the group about their own personality patterns and relating styles. Consider taking the free on-line Jung Typology Test at <http://www.humanmetrics.com/cgi-win/JTypes1.htm> to become more familiar with your own relating patterns and style.

### Procedure:

1. Introduce the activity by commenting that outreach is done by people with all kinds of personality types. For example, some are quite outgoing, whereas others are more introverted. There is no right or wrong style. However, understanding your own basic personality patterns can be useful for your outreach activities. It may in fact influence with which homeless individuals you work most effectively.
2. Ask participants if any have ever completed a self-assessment tool such as the Myers-Briggs Personality Inventory (MBTI), the enneagram, or the Jung Typology Test. If so, ask what they might have learned from it that relates specifically to their own style in doing outreach. For those who have never completed such a tool, invite them to reflect on what they know about their own relating style and how it affects their outreach.
3. Provide information to participants about the Jung Typology Test that can be found on-line at <http://www.humanmetrics.com/cgi-win/JTypes1.htm>. This test is based on the Jung-Myers-Briggs approach to personality.

## 3C: Listening With All Six Senses

“Let us not underestimate how hard it is to listen and to be compassionate. Compassion is hard because it requires the inner disposition to go with others to the place where they are weak, vulnerable, lonely and broken. But ... our spontaneous response ... is to do away with suffering by fleeing from it or finding a quick cure for it. As busy, active, relevant people we want to [make] a real contribution. This means first and foremost doing something to show that our presence makes a difference. And so we ignore our greatest gift, which is our ability to be there, to listen and to enter into solidarity with those who suffer.”

– Henri Nouwen

“The finest act of love you can perform is not an act of service, but an act of contemplation, of seeing. When you serve ... you help, support, comfort, alleviate pain. When you see (others) in their inner beauty and goodness you transform and create.”

– Anthony De Mello

### **Purpose**

To enhance listening skills and appreciate the fundamental importance of listening in outreach and engagement

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 Communication “Eye-Opener”**

Purpose: To illustrate the challenges of effective communication

Time: 10-15 minutes

Materials:

Handout: Communication “Eye-Opener”

Blank sheets of paper, pencils

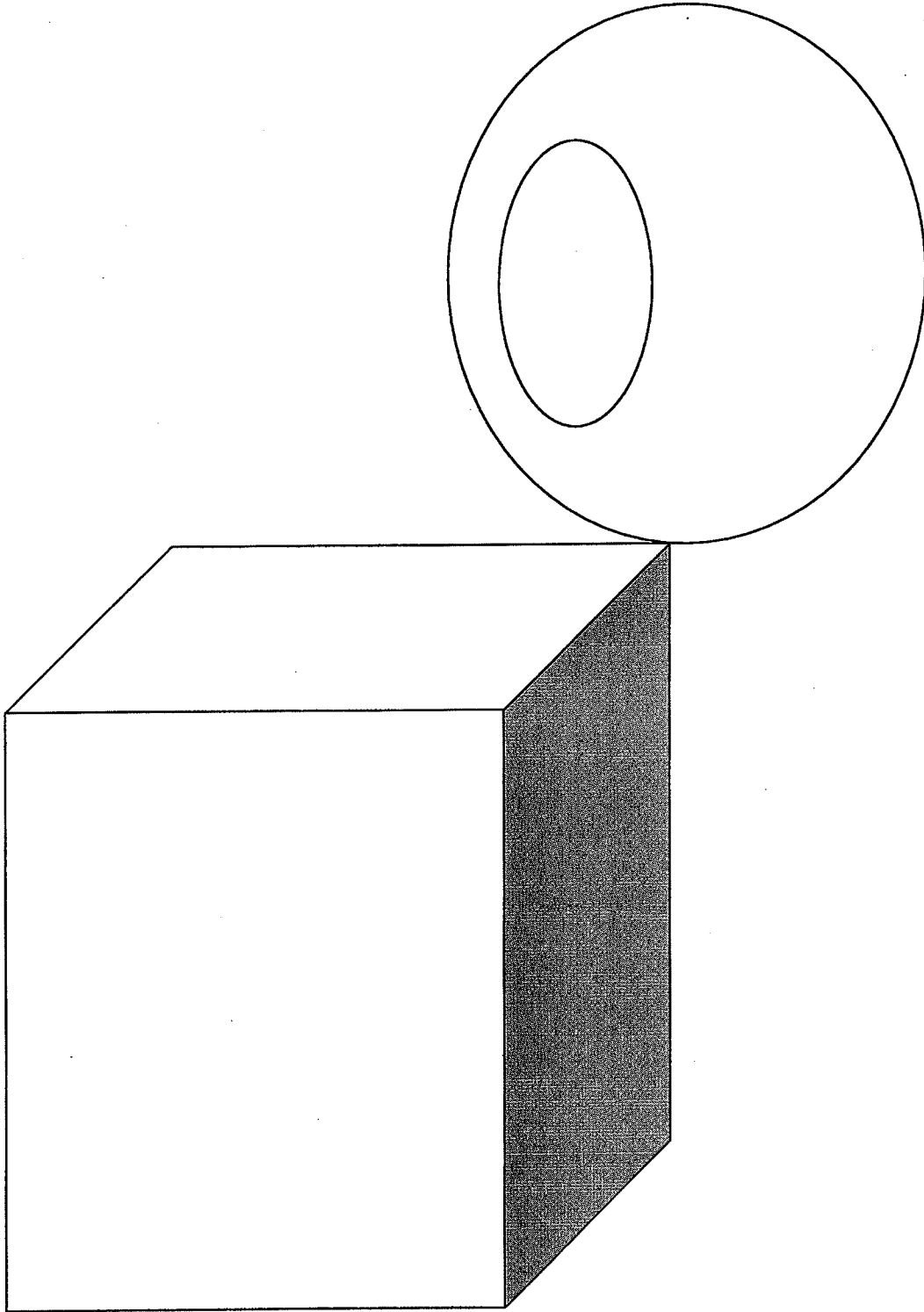
Preparation:

Review the procedure to be familiar with the exercise. Try it with a friend.

Procedure:

1. Explain that the reason for doing this simple exercise is to illustrate the challenges and complexities of communication.
2. Break into pairs and instruct each person to sit back-to-back to one another.
3. Distribute a blank sheet of paper and pencil to one person in each pair. Ensure that he or she has a hard surface on which to write.
4. Distribute a copy of the handout to the other person in each pair. Be sure that none of the participants who were given the paper and pencil has any opportunity to see or even catch a glimpse of the handout. (If this should occur, a new handout can be created using different simple shapes.)
5. The task of the person with the handout is to give detailed verbal instructions to the drawing partner so that he or she can create a drawing that looks the very same as the shapes/figures on the handout. The drawing partner listens to the instructions but is not permitted to ask questions or respond verbally in any way. Obviously, neither is permitted to look at each other’s paper during the exercise.
6. Allow several minutes for the pairs to work on the drawing exercise and then have everyone stop at the same time. Have the pairs compare the drawing that the drawer “heard” with the images on the handout.
7. Take time as a group to talk about the experience of doing this exercise for both partners. How accurate was the drawing? What were the challenges? Frustrations? How attentive to detail was the person who was giving instructions (e.g. to size, dimensions, shading, position on the page)? How helpful would it have been if the drawer had been permitted to verbally interact with the partner? How does this illustrate the difficulties of communication in our daily relationships? In outreach?

# Communication “Eye-Opener”



## **ACTIVITY 2 The Power of Listening**

Purpose: To increase appreciation for the power of listening in our lives for both the one being listened to and the listener

Time: 30-35 minutes

### Materials:

Handout: The Power of Listening

Optional: CD or audiotape player, instrumental music selection, and/or poetry or a short story

### Preparation:

Listening is integral to our lives. It provides us with important information and insights. It keeps us focused, balanced and connected. Listening is essential to how we relate with one another, with ourselves, with nature, with the spiritual realm, and with other aspects of the world around us.

Listening is perhaps the single most powerful and effective tool that outreach workers have at their disposal. It lies at the heart of this work. Henri Nouwen observes that "our greatest gift ... is our ability to be there, to listen and to enter into solidarity with those who suffer."

People see themselves and others differently when they are listened to well. Listening is the key to building trust, gaining understanding, and creating the conditions for taking action. Without it, little can be done to effect change or accomplish anything of lasting value.

Listening is an art and a technique, an attitude and an activity. It is a difficult skill to master for it requires much more than the use of one's ears and merely "hearing the words." Listening well requires the use of one's whole being. Like any other skill, it needs to be learned and practiced over and over.

Listening is ultimately a commitment to enter actively and deeply into a relationship with another human being. Though not always easy, it is through such relationships that the listener can also be renewed and rewarded by the relationship itself and the gifts that the other brings to it.

Review the handout and take time to "listen" for yourself to what it has to say. In addition, review the activity steps and make preparations accordingly.

### Procedure:

1. Introduce the activity by providing a synopsis of the comments above including your own insights about the power of listening.

2. Next, move into a period of silence. Comment that even in silence, perhaps especially in silence, there is much to be “listened to” in relationship to oneself and the world beyond. Encourage everyone to be as quiet as possible, to close their eyes if they wish, and to listen carefully to the “silence.”

3. After three minutes or so, facilitate a brief discussion about what participants “heard” externally and internally in the silence (e.g. outside noises, their own breathing, a cough, a feeling of calm or anxiety, distracting or creative thoughts, etc.) and how it affected them.

4. As a next step, play a piece of instrumental music (e.g. classical, jazz or some other style) for about three minutes. Elicit comments about how music can affect us. Alternatively, read a piece of poetry or a short story and elicit similar comments.

5. Comment that just as we are impacted when we listen attentively to silence, music, or words, so are we affected when we listened mindfully to another in the context of a relationship. This requires a special commitment of time and attention, but the potential rewards are well worth the effort.

6. Go over the various points in the handout on “The Power of Listening.” Then ask participants for some examples when someone had listened well to them and how they knew this was the case. Next, ask for examples of times that they were the ones who listened well and how they knew this to be the case.

7. Conclude the activity by reading the quotes above by Henri Nouwen and Anthony De Mello. De Mello is speaking about a similar concept to the “power of listening” but uses the language of “seeing” instead of “listening.”



# The Power of Listening

"If speaking is silver, then listening is gold."  
Turkish proverb

- Listening is a magnetic and creative force.
- When we are listened to, it creates us, makes us unfold and expand.
- When we are listened to, ideas begin to grow within us and come to life.
- People are more happy and free when they are listened to.
- Creative listeners want others to be themselves, even at their very worst. True listeners know that if you are bad-tempered, it does not mean you are always so.
- As we listen, there is an alternating current that recharges us so we are constantly being recreated as well.
- Unless you listen, you can't know anyone. You will know facts and have impressions, but not really know them.
- The most serious result of not listening is boredom (for it is really the death of caring and love).
- Not listening seals people off from each other more than anything else does.
- Listening provides the fertile soil from which positive decisions and changes can develop.
- Listening is one of the best gifts of all we can offer to people experiencing homelessness.

Adapted from *Strength to Your Sword Arm: Selected Writings*, Brenda Ireland, Holy Cow Press, 1992

## ACTIVITY 3 Listening Well

Purpose: To increase awareness about the profound influence that listening well, and *not listening*, has on others

Time: 30 minutes

Materials:

Handout: Six Habits of Highly Ineffective Listeners

Handout: Listening Well

Preparation:

Review the content of the two handouts and the procedure steps for this activity.

Procedure:

1. Explain with “tongue-in-cheek” that this activity is designed to help participants improve their *ineffective* listening “skills” because outreach workers sometimes get rusty from not using them.
2. Distribute the “Six Habits of Highly Ineffective Listeners” handouts. Tell participants to ignore the parenthetical comments on the handout. Review the six habits (e.g. On-Off Listening, Red Flag Listening, etc.) and instruct participants how to practice them providing demonstrations and tips as needed!
3. Divide the group into pairs. Instruct one partner to speak for about a minute on the topic: “Something I’m really proud of is ...” (or some similar topic). The listener is instructed to practice the various ineffective listening skills they just learned or, otherwise, to act in an inattentive, distracted and disinterested manner (but not walk away) while the speaker tells her/his story. Have them switch roles and repeat the exercise.
4. With your “tongue-back-in-its-normal-location,” ask each person to take turns speaking on the same topic noted above but this time the listener is to be engaged and interested in the conversation.
5. After each has taken their respective turns, solicit comments about the contrasting ways that participants experienced the two listening approaches.
6. As needed, refer back to the handout on the “Six Habits of Highly Ineffective Listeners” and review and discuss the suggestions in parentheses about how to overcome barriers to listening effectively.
7. Reiterate that how we listen to others can have a profound influence on them. By listening well we can contribute to others feeling more empowered, creative, and passionate, or conversely, we can create the conditions by which they feel discouraged and diminished by listening poorly or not at all.

8. Spend the remaining part of the activity carefully reviewing and discussing with the group the handout "Listening Well" which is written specifically about outreach to chronically homeless people. Invite different people in the group to read aloud the seven statements, allowing for some discussion after each one.

# Six Habits of Highly *Ineffective* Listeners

## 1) On-Off Listening

Occurs because most of us think about four times as fast as the average person can speak. Thus, the listener has  $\frac{3}{4}$  of a minute of "spare thinking time" in each listening minute to think about such things as personal affairs, concerns, and troubles.

*(One can overcome this by paying attention to more than the words, watching non-verbal signs like gestures, eye contact, hesitation, voice tone to pick up the feeling level.)*

## 2) Red Flag Listening

Sometimes, when we hear certain words, ideas, or opinions expressed, we become upset and stop listening. These expressions, often cultural, political, or religious in nature, become "like a red flag to a bull." We find ourselves reacting and thus, tuning out the speaker.

*(The first step to overcome this barrier is to discover our personal red flags. Also, try listening attentively to someone more sympathetic to the issue.)*

## 3) Open Ears – Closed Mind Listening

Sometimes we decide rather quickly that either the subject or the speaker is boring, and what is being said makes no sense. We decide we can predict what the person knows or will say; thus, we conclude there is no reason to listen because we will hear nothing new.

*(Better to listen and find out for sure if our predictions are accurate, rather than assume so.)*

## 4) Glassy-eyed Listening

Sometimes we look at a person intently and seem to be listening. However, our minds are far away absorbed in our own thoughts. We get glassy-eyed with a dreamy expression on our faces. We can tell when other people look this way, and they can see the same in us.

*(Postpone daydreaming till another time. If others appear glassy-eyed, suggest a change of pace or break.)*

## 5) Too-Complicated-For-Me Listening

When we are listening to ideas that are too detailed, wandering, or complex, we often stop paying attention and "give up" trying to understand. Our thoughts then go elsewhere.

*(It's important to keep trying to understand by asking clarifying questions.)*

## 6) Don't Rock the Boat Listening

We don't like to have our favorite ideas, prejudices, and points of view challenged or overturned. So, when someone says something that clashes with what we believe, we may unconsciously stop listening or even become defensive and plan a counterattack.

*(Best to keep listening carefully and non-defensively, so we can do a better job of responding constructively.)*

# Listening Well

*Listening well is as powerful a means  
of communication and influence as to talk well.*

— John Marshall

*First*, a good companion needs to listen well. I have found it **important to listen intently, to give the other my undivided attention**, even through pauses and silences. People need time to find a word, to name a feeling, to remember, especially if their brain is disturbed or their life situation is fraught with struggle. Though colleagues have suggested I carry a pager or cell phone, I don't. I don't want to be interrupted when listening to another. When I am with someone in need, I want to listen as deeply and as long as is necessary with as much attention and care as I can muster.

*Second*, I listen not so much for details as for feelings and for **the themes** of the conversation. How can I acknowledge the wealth of sensations, the emptiness or turmoil that another is going through? There are a range of common human themes: the need for shelter, food, survival, the yearning for safety and security, issues of relationship, struggles with decision, right and wrong, the desire for understanding and acceptance, questions of meaning and purpose, a desire for useful and productive work, health. What are the life themes that are important to this person?

*Third*, when I am listening, I **keep in mind that no one thing ever defines or determines another person**. Only over time and in the context of community can I begin to fully know and understand who an individual may be.

*Fourth*, I **take great care with responses**. I often ask for clarification. "Help me understand." "I'm not sure what that means. Could you say more?" "How so?" "What are you experiencing?" "Is this something that has happened with you before?"

*Fifth*, as I listen to another, **I listen also to myself**. What feelings are being stirred in me? What thoughts and memories are emerging? Not that I will share all this, but it helps me to begin to empathize. Listening to myself is a reminder that, in sharing this journey with another, I am opening myself to a new experience. In engaging, I will be affected.

*Sixth*, as I listen to another, **I listen especially for the possibilities – the future that is available in this journey**. What strengths, what resources, what capacities does this person carry and have available? I listen for the hope, the dreams, the meanings that are important to this person. What draws the person on? What gives the person a sense of purpose and power?

*Seventh*, as I listen, **I ask how I can best promote the journey toward health and wholeness**. I always test my intuitions and ideas with the other person and with the helping team. "What do you think?" "Is this agreeable?" "How do you feel about doing this?" "Does this seem helpful?" These ways of listening honor the other. More than anything I can give, these are the ways that make for companionship."

Rennebohm, Craig, D. Min. "Approach and Companionship in the Engagement Process," in Compton, B. and Galaway, B. *Social Work Processes*. Pacific Grove: Brooks/Cole Publishing Company, 1999.

## **ACTIVITY 4 Reflective Listening**

Purpose: To recognize the vital importance of listening in outreach and to develop practice skills in the three basic levels of reflective listening

Time: 35-40 minutes

Materials:

Handout: Reflective Listening

Handout: Reflective Responses

Preparation:

Reflective listening is an approach to listening that seeks understanding, not necessarily agreement. It seeks to understand both the meaning of what is being said aloud and what is not. Reflective listening is an attentive, respectful, non-judgmental approach to providing care.

People experiencing homelessness express gratitude when outreach workers (and others) are willing to take the time and effort to understand, rather than giving advice or leaping into a "fix-it" mode. Reflective listening is a way of offering true hospitality and acceptance.

Reflective listening is not a problem-solving approach as such. However, it is the vehicle for getting there. When someone feels heard and understood, it then becomes easier to take the steps needed to address problems. As Carl Rogers, the noted psychologist, once stated: "People only listen when they feel listened to."

While the use of reflective listening is beneficial in all relationships, it can be particularly helpful in breaking down barriers and minimizing resistance with individuals experiencing anger, frustration, or are feeling "stuck." It does not try to control, but to empower.

Outreach workers must use reflective listening carefully. It is not just a parroting technique; it must derive from genuine caring. Otherwise, it becomes a fraudulent exercise.

For some background reading about effective listening in preparation for this activity, go to <http://www.ianr.unl.edu/pubs/family/g1092.htm#lrl>. You will find there an article by Herbert G. Lingren entitled "Listening – With Your Heart As Well As Your Ears."

Procedure:

1. By way of introduction, summarize the comments above in the preparation section.

2. Distribute and go over the content on the Reflective Listening handout. Emphasize that in order to listen effectively, one needs to listen reflectively. Be sure to review and thoroughly discuss the three basic levels of reflective listening: repeating or rephrasing, paraphrasing, and reflection of feeling. These constitute the core skills of listening well.

3. Distribute the handout: Reflective Responses to begin the practice phase of the activity. Stay in the large group or divide into smaller groups.

4. Explain that for each sentence stem on the handout, participants are to come up with various examples of reflective listening responses, starting with the first level (repeating or rephrasing), then the second (paraphrasing), and the third level (reflection of feeling). Remember to emphasize that in "real life" all levels are useful and should be intermingled.

5. Continue the activity by moving into role-playing in pairs. Each partner can take turns being the reflective listener/outreach worker while the other, playing the role of a homeless person, talks about any topic they wish for several minutes. Encourage the listener to use all three levels of reflective listening at least one or two times each during the role-play.

6. Close the activity by eliciting comments from participants about how they experienced reflective listening in the roles of being the one being listened to and being the listener.



# Reflective Listening

"Listening looks easy, but it's not simple. Every head is a world."  
Cuban proverb

Reflective listening is a primary skill in outreach. It is the pathway for engaging others in relationship, building trust, and fostering motivation to change. Reflective listening appears deceptively easy, but it takes hard work and skill to do well.

Sometimes the "skills" we use in working with clients do not exemplify reflective listening but instead serve as roadblocks to effective communication. Examples include misinterpreting what is said or assuming what a person needs.

It is vital to learn to *think* reflectively. This is a way of thinking that accompanies good reflective listening that includes interest in what the person has to say and respect for the person's inner wisdom. Its key element is a hypothesis testing approach to listening. What you think the person means may not be what they really mean. Listening breakdowns occur in any of three places:

- Speaker does not say what is meant
- Listener does not hear correctly
- Listener gives a different interpretation to what the words mean

Reflective listening is meant to close the loop in communication to ensure breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This may feel presumptuous, yet it leads to clarification and greater exploration, whereas questions tend to interrupt the client's flow. Some people find it helpful to use some standard phrases:

- "So you feel..."
- "It sounds like you..."
- "You're wondering if..."

There are three basic levels of reflective listening that may deepen or increase the intimacy and thereby change the affective tone of an interaction. In general, the depth should match the situation. Examples of the three levels include:

1. Repeating or rephrasing – listener repeats or substitutes synonyms or phrases; stays close to what the speaker has said
2. Paraphrasing – listener makes a major restatement in which the speaker's meaning is inferred
3. Reflection of feeling – listener emphasizes emotional aspects of communication through feeling statements – deepest form of listening

Varying the levels of reflection is effective in listening. Also, at times there are benefits to over-stating or under-stating a reflection. An overstatement (i.e. an amplified reflection) may cause a person to back away from a position while an understatement may lead to the feeling intensity continuing and deepening.

(Adapted from Motivational Interviewing materials by David B. Rosengren, Ph.D. and from Motivational Interviewing by Miller & Rollnick, 1991)

# Reflective Responses

In the course of doing outreach, various homeless individuals make the statements listed below. How might you respond to these statements using the three different levels of reflective listening?

- 1) Repeating or rephrasing
- 2) Paraphrasing
- 3) Reflection of feeling

*Example: That shelter is the last place in the world I'd ever stay.*

1. So, staying in that shelter is certainly not an option for you.
2. It sounds like you've had some pretty bad experiences at that shelter.
3. You seem pretty upset with the way that shelter operates.

*I like getting high, but something has got to give. I just can't go on like this anymore.*

*It's been over a year since I've had an HIV test.*

*You know if she would just back off, this situation would be a whole lot less tense and then these things wouldn't happen.*

*Everybody out there is trying to mess with my head.*

*I'm trying to get a job, but I've got to look out for my kids.*

*Nobody at that clinic wants to help me. They can't even speak my language.*

*Usually when I get depressed, I just try to stay busy, and it eventually goes away. But this time, I just don't know...*

*I keep thinking I should get this checked out at the clinic, but I just never seem to make it there.*

Adapted from exercise by Douglass Fisher, M.A. & David Rosengren, Ph.D.

## **ACTIVITY 5 Paraphrasing – “You Mean That ...”**

Purpose: To practice paraphrasing – the “second level” of reflective listening that goes beyond a simple restatement to a level in which the listener makes a guess, or tests a hypothesis, about what the speaker means.

Time: 10-15 minutes

Materials: None

Preparation: Refer to the Reflective Listening handout in Activity III in this section for a refresher on the three basic levels of reflective listening. Review the activity described below and try it out with someone in preparation for facilitating the exercise.

### Procedure

1. Introduce this simple activity by explaining that its purpose is to illustrate paraphrasing – the second level of reflective listening. Remind participants of the three levels of reflective listening.
2. Form into groups of three. One person makes a general statement of a personal nature such as “I am a creative person”, “I like to be organized”, “I’m adventurous”, etc.
3. The other two participants try to understand more fully what the person might mean by his/her statement. They take turns making “educated guesses” by asking: “You mean that ... ?” For example, to a person who says “I am creative” the listener might ask: “You mean that you like to make things with your hands?” or “You mean you like to write poetry?” or “...play music?” “...cook special meals?” “... make puns?” ... etc.
4. To each question the speaker indicates whether the guess is true, not true, or perhaps partly so without further elaboration and then responds to the next question. The exercise continues with questioners putting forth their hypotheses in a fairly rapid-fire manner so that a number of possibilities are explored.
5. Allow two to three minutes for each speaker to field and respond to questions others may have. Give each person in the group a chance to make a personal statement and receive questions.
6. Conclude by noting that by asking “leading questions” such as “You mean that ...?” one can learn a great deal about another person.

## **ACTIVITY 6 Summarizing**

Purpose: To practice the skill of summarizing – a particular application of reflective listening

Time: 25 minutes

Materials: Handout: Summarizing

### Preparation:

Review the handout. Summarizing statements provide a checkpoint to test whether accurate communication is occurring and provide an opportunity for clarification and amplification of what is being said. Summarizing also provides the speaker with concrete evidence that he or she is being heard. Often times summarizing can lead to taking the “next steps” in the change process.

Note that summarizing is especially useful at transition points in the conversation. When making a summary statement, it is valuable to emphasize the individual’s “change statements” that indicate problem recognition, concern, intent to change, or optimism about change being possible. Conversely, summarizing can also be used effectively when someone is expressing ambivalence or even denying that a problem exists.

### Procedure:

1. Distribute the handout to the group. Review the structure of making summarizing statements and discuss when it is particularly helpful to make such statements. Emphasize focusing on change statements when summarizing.
2. Divide into pairs and set up a role-play between a person experiencing homelessness and an outreach worker. Have the speaker, playing the role of a homeless person, talk about any topic of his/her choosing for up to five minutes. The listener is instructed to make approximately three summarizing statements during this time at appropriate intervals in the conversation. Emphasize the need for the listener to pay attention to change statements when summarizing. At the end of the conversation, instruct the listener to make a final statement that summarizes the whole of the preceding conversation. Remember that these statements are to be concise and take relatively little time.
3. Reverse roles and follow the same instructions as in step two. Debrief the activity after participants have had the opportunity to play both roles.

# Summarizing

Summaries are special applications of reflective listening. They can be used throughout a conversation but are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end.

Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change.

## Structure of Summaries

- 1) Begin with a statement indicating you are making a summary. For example:
  - Let me see if I understand so far ...
  - Here is what I've heard. Tell me if I've missed anything.
- 2) Give special attention to Change Statements. These are statements made by the client that point towards a willingness to change. Miller and Rollnick have identified four types of change statements, all of which overlap significantly:
  - Problem recognition *"My use has gotten a little out of hand at times."*
  - Concern *"If I don't stop, something bad is going to happen."*
  - Intent to change *"I'm going to do something, I'm just not sure what it is yet."*
  - Optimism *"I know I can get a handle on this problem."*
- 3) If the person expresses ambivalence, it is useful to include both sides in the summary statement. For example: "On the one hand ..., on the other hand ..."
- 4) It is legitimate to include information in summary statements from other sources (e.g. your own clinical knowledge, research, courts, family).
- 5) Be concise.
- 6) End with an invitation. For example:
  - Did I miss anything?
  - If that's accurate, what other points are there to consider?
  - Anything you want to add or correct?
- 7) Depending on the response of the client to your summary statement, it may lead naturally to planning for or taking concrete steps towards the change goal.

(Adapted from Motivational Interviewing materials by David B. Rosengren, Ph.D. and from Motivational Interviewing by Miller & Rollnick, 1991)

## **ACTIVITY 7 Listening Self-Assessment**

Purpose: To assess your own listening skills

Time: 10 minutes

Materials: Computer with web access

Preparation: Go to <http://www.highgain.com/SELF/index.php3> or search for International Listening Association, click on Listening Resources, and again on Listening Self-Assessment. This is one of a number of websites with self-assessment tools for listening skills. You may want to browse for others as well.

Procedure:

1. Take the self-assessment and check your scores.
2. Take time to reflect on what this might tell you about your listening skills. Discuss this with another person if you wish and request feedback from them.

# Module 4: COMPANIONSHIP

## SHARING THE JOURNEY

### **Purpose**

The purpose of Module 4 is to explore frameworks for engagement that inform the companionship phase, examine prevalent health and social issues encountered in outreach, enhance worker's assessment skills, and to increase understanding about how to motivate client change in the outreach and engagement relationship.

## **4A: Frameworks of Engagement**

### **Purpose**

To explore four conceptual frameworks that help to inform the outreach and engagement process

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.



## **ACTIVITY 1 Hospitality – Creating Space for the Stranger**

Purpose: To explore the concept of *hospitality* as a useful framework for engagement

Time: 15-20 minutes

Materials: Handout: Hospitality – Creating Space for the Stranger

### Preparation:

Henri Nouwen, Dutch author and teacher, provides a rich understanding of the concept of hospitality. Defined as “creating free and friendly space for the stranger,” this approach is especially pertinent for outreach to people experiencing homelessness.

Read and reflect on the material in the handout and review the suggested discussion questions below.

### Procedure:

1. Have one or several participants read the handout aloud to the group and/or summarize the notion of hospitality as described by Nouwen.
2. Invite questions and facilitate a discussion using the following questions as a guide:
  - What other phrases describe the idea of providing hospitality in addition to those mentioned in the handout (e.g. creating space, providing a welcoming face)?
  - How is the concept of “providing hospitality” similar to and distinctive from the idea of “providing service?”
  - In what circumstances have you been “the stranger” who was offered the gift of hospitality by someone else? What was that experience like?
  - In addition to the examples in the handout, what are some specific ways you might offer hospitality in your outreach work?
  - How could your team or organization improve upon the ways it provides “free and friendly space for the stranger?”

# Hospitality – Creating Space for the Stranger

Estrangement, a feeling of not belonging, is one of the hallmark characteristics of the experience of homelessness. One becomes separated from usual activities, relationships, and sense of place and purpose in the world. Literally, one becomes a stranger. The longer homelessness persists, the more deeply ingrained this sense of alienation becomes.

“Offering the gift of hospitality” is a useful way for care provider’s to think about overcoming this estrangement. In his book *Reaching Out*, Henri Nouwen defines hospitality as “*creating free and friendly space for the stranger.*” This definition takes us well beyond images of tea and sandwiches being shared in a pristine setting. Instead it points us towards new and deeper relationships in our lives.

Hospitality offered to the stranger is an invitation to a relationship – a relationship that provides a welcoming face and presence – that creates a sense of refuge from an often impersonal, hostile world. Hence, the person experiencing homelessness can have a taste of being “at home” in the context of a safe, friendly relationship.

A hospitable relationship comes with no strings attached. It does not pass judgment and does not make demands. Instead, it provides a space in which the other can freely explore one’s own needs, abilities and hopes. Such a relationship becomes both a “resting place” and a “guiding light.” It provides a place of self-reflection and restoration. It instills and renews hope.

The power of hospitality lies not in coercion but in careful listening, reflection, information and kindly persuasion. It encourages, but does not force. It is built upon the trustworthiness, competency and integrity of the provider.

When we think of our own experiences of being graced with the hospitable presence of another, we remember it as calming, orienting and renewing. It is like remembering who we are – returning to our

true home – so that we can once again move ahead more confidently in our lives. The absence of such a presence often leads to isolation, dis-orientation, confusion and despair. Like all of us, people experiencing homelessness need hospitable relationships in their lives.

Hospitality is offered in many ways – sometimes by a simple gesture of acknowledgement, a warm smile, a cup of coffee, listening patiently without interrupting, offering information, a word of encouragement, or simply by being present with the other person in silence. Hospitality requires time, patience and kindly persistence. It cannot be rushed. It sees the “bigger picture” rather than seeking the “quick fix.”

As trust within the relationship builds, a sense of companionship develops (see Rennebohm’s Relational Outreach and Engagement Model). Time is spent together on a more predictable basis. The homeless individual shares more and more of his or her story. Small tasks are shared. Inquiries are made about other resources. In time, hospitality leads to increasing the “circle of care” to help the individual access needed resources and services. In this manner, medical, housing, financial, counseling and other treatment and social service needs are met.

Over time, as the individual progresses toward greater stability, the relationship moves into a phase of increasing mutuality. It is not just one-sided. Once a stranger, the individual has now become a neighbor and friend. We discover that our stories are interwoven and that we are bonded by our common humanity. In this mutuality, each person is recognized for the strengths and gifts that they bring to the relationship as well as to the larger community.

In the end, hospitality that is given becomes hospitality received.

- Ken Kraybill

## ACTIVITY 2 The Power of Story

"All sorrows can be borne if you put them  
into a story or tell a story about them"  
Isak Dinesen

Purpose: To be reminded of the power of "story" in outreach

Time: 15-20 minutes

Materials: Handout: "Story as a Framework for Engagement"

Preparation:

Read and reflect on the handout as well as the comments below. Note that each encounter we have in outreach is an encounter with a story. Each person we meet carries with them a unique personal story that has a powerful influence on them. These life narratives hold the keys to better understanding how we can be of assistance to others.

We are obliged to view other people's choices and behaviors in the context of their personal story. This will lead to a truly compassionate response. For example, if we know someone's story has included a history of childhood trauma and abuse, we will be able to better understand their difficulties with trust. When we refuse to see the bigger picture of someone's life, we tend to be judgmental and offer inadequate care.

Terry Tafoya, PhD, Native American teacher and storyteller, suggests that our personal stories are woven like spider webs. They twist, turn, spiral and circle around instead of moving in straight lines. Sometimes our stories demonstrate our very best qualities and other times our vulnerabilities and weaknesses.

We rely on stories to be reminded of our universal struggles and aspirations. As Jean-Paul Sartre once said, "A man is always a teller of tales, he lives surrounded by his stories and the stories of others, he sees everything that happens to him through them; and he tries to live his own life as if he were telling a story."

It is difficult to move ahead in life without having a sense of grounding in one's own story. By listening to others' stories, we can be of help in restoring some order from chaos, bringing understanding to what is confounding, and helping others remember who they are. In return, we are often reminded of who we are.

Procedure:

1. Introduce the topic of story based on the comments above and your own reflections. Have someone read aloud the handout "Story as a Framework for Engagement" by Craig Rennebohm.
2. Break into small groups of two or three. Comment that it is relatively easy to relate the enjoyable moments of our lives, but the more distressing stories can be difficult to share.
3. Ask participants to share with each other a brief description of an experience or period of time in their life that was particularly enjoyable.
4. Next, ask them to think back on a time when "telling your story" may have been difficult, perhaps due to physical or emotional pain, illness, stress, confusion, or loss. Was there someone there who was able to "help you piece your story back together" in some way? If so, what was that experience like? Acknowledge that this level of sharing may feel risky for some. Suggest they share only as much as they feel comfortable, or to focus particularly on the helpful characteristics of the one who was present with them.
5. Take time to discuss some of the following questions to increase participants' appreciation for the significance of story in our lives.
  - What are some reasons why a person experiencing homelessness might have difficulty remembering his/her story, or at least certain parts of it?
  - What are some reasons why a homeless person might be reluctant or fearful to tell their story?
  - How do you define and determine the "truth" of someone's story? To what extent is this truth related to factual accuracy?
  - Below are some quotes from various writers about the notion of *story*. How might these thoughts and observations be relevant to your outreach work with homeless people?
    - "All sorrows can be borne if you put them into a story or tell a story about them" – Isak Dinesen
    - "A man is always a teller of tales, he lives surrounded by his stories and the stories of others, he sees everything that happens to him through them; and he tries to live his own life as if he were telling a story" – Jean-Paul Sartre
    - "As long as we have stories to tell to each other there is hope" – Henri J. M. Nouwen
  - To what degree do you feel comfortable sharing parts of your own story with someone to whom you are reaching out? Under what circumstances?

# Story as a Framework for Engagement

Everyone has a story. Sharing our stories creates a common ground on which we can meet each other as human beings. Our stories are neither "right nor wrong." They are simply our stories.

Everyone has a story. Some of us can tell our stories with an unclouded memory for our past, clarity about our present situation, and a realistic understanding of where our journey is heading in life.

Some of us find telling our story extremely difficult. Our past may be painful and deeply hidden from memory. We may never have had much support in putting together any real, coherent sense of ourselves in relationship to others. Current stresses in our life may be upsetting or confusing the sense of who I am and where I have been and where I am going. I may have a developmental disability, which makes it difficult to put my story together.

Mental illness, intoxication, neurological disorders and brain injuries can deprive a person of the capacity to tell their story and locate themselves with others and the world. In the midst of illness a person's story may take on bizarre dimensions. Difficulty in sharing a coherent story or the presentation of a very disjointed or strange story may be an indication of disability, and a need for a patient, especially careful approach to working together.

Inviting another to share their story can be a non-threatening way to gain mutual trust, and develop a picture of a person's situation and needs. A willingness to share a little of our own story in the conversation helps build the common ground.

We end, in a sense where we began. As we share our stories over time, hopefully we are both enriched. We have walked a little way on the journey together. At best, I have been able to add a little something to another's story, some hope, some concrete help, some encouragement, and they have added something of their courage, their humanness, and their experience to my story.

Each of us has a story. We live in a world that has a basic narrative quality to it. Life is unfolding, coming out of the past, developing in the present, moving on into a future. We are all seeking to locate ourselves in the drama, putting together some more or less coherent, meaningful sense of ourselves and our relationship to others and the world.

Every encounter we have is a small piece of the larger story. Every encounter is an opportunity to listen and share, and to help move our stories along with care and compassion.

Craig Rennebohm

## **ACTIVITY 3 “What Does It Mean To Care?”**

Purpose: To gain a deeper understanding of the word “care” based on its root meaning and how it relates to outreach

Time: 15-20 minutes

Materials: Handout: What Does It Mean To Care?

### Preparation:

Read and reflect on the handout. The author, Henri Nouwen, provides a provocative and compelling statement about what it means to care. Think about how you might respond to the questions in step 3 of the procedure below.

### Procedure:

1. Write the word care at the top of a flipchart sheet. Ask participants what words or phrases come to mind when they think about offering care to someone. List these on the sheet.
2. To expand upon this concept, have someone read aloud the handout on the meaning of care written by Henri Nouwen or give a summary of the main points.
3. Facilitate a group discussion about what it means to care, using the questions below to guide the conversation.
  - Why does Nouwen say that care has become an ambivalent word in common usage?
  - What is the meaning of the word care based on its roots in the Gothic word “kara”? Does this surprise you in any way? How does it change your own perspective on the meaning of care?
  - The author suggests that the root meaning of care challenges the common view of caring for others as an “attitude of the strong toward the weak, the powerful toward the powerless, of the haves toward the have-nots.” How so?
  - What is meant by the phrase “cure without care”? What are some examples in outreach that might illustrate an approach of cure without care?
4. Close the activity by having participants write down ideas and discuss some specific ways in which they might “lament, grieve, experience sorrow with” the homeless individuals they meet.

## What Does It Mean To Care?

The word care has become a very ambivalent word. When someone says: "I will take care of him!" it is more likely an announcement of an impending attack than of tender compassion. And besides this ambivalence, the word care is most often used in a negative way. "Do you want coffee or tea?" "I don't care."

Real care is not ambiguous. Real care excludes indifference and is the opposite of apathy. The word "care" finds its roots in the Gothic "kara" which means *lament*. The basic meaning of care is: *to grieve, to experience sorrow, to cry out with*. I am very much struck by this background of the word care because we tend to look at caring as an attitude of the strong toward the weak, of the powerful toward the powerless, of the have's toward the have-not's. And, in fact we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.

Still, when we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving much advice, solutions, or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not-knowing, not-curing, not-healing and face with us the reality of our powerlessness, that is the friend who cares.

Our tendency is to run away from the painful realities or to try to change them as soon as possible. But cure without care makes us into rulers, controllers, manipulators, and prevents a real community from taking shape. Cure without care makes us preoccupied with quick changes, impatient and unwilling to share each other's burden. And so cure can often become offending instead of liberating.

It is therefore not so strange that cure is not seldom refused by people in need. Not only have individuals refused help when they did not sense real care, but also oppressed minorities have resisted support, and suffering nations have declined medicine and food when they realized that it was better to suffer than to lose self-respect by accepting a gift out of a non-caring hand.

-- Henri Nouwen



## **ACTIVITY 4 Entering the Shadows**

Purpose: To acknowledge the prevalence of trauma and abuse, past and present, in the lives of many people who experience homelessness

Time: 25-30 minutes

Materials:

Handout: Entering the Shadows

Resource Paper: Trauma and Abuse ... Entering the Shadows

Preparation:

The following three resources are recommended for background reading on the topic of trauma and homelessness.

- Identifying and Responding to Violence among Poor and Homeless Women from the Better Homes Fund in collaboration with the HCH Clinicians' Network <http://www.nhchc.org/domviolence.html>
- Trauma and Homelessness, April 1999 issue of Healing Hands, newsletter of the HCH Clinicians' Network, at <http://www.nhchc.org/hands/1999/apr/aprhands.html>
- "Trauma and Victimization" by Susan Fleischman in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Review the handout and the resource paper. The poems included there are powerful statements about the impact of trauma and abuse on the lives of the homeless and formerly homeless women who wrote them. The intent of this activity is to acknowledge that the experience of trauma and abuse is not uncommon for a significant number of women, men, youth and children we meet in outreach. Of course, this has been the experience for some care providers as well.

Outreach workers need to be attuned to the often-subtle cues that abuse may be part of someone's experience and hear individual's stories as they are freely offered. This is described here as a willingness to "enter into the shadows." Outreach workers are not expected to provide therapy for persons with a history of trauma and abuse, but can and should at least respond in a therapeutic manner, name the abuse for what it is, and help to find the needed resources for those who may want treatment. As always, workers must at very least seek to do no further harm.

Procedure:

1. Consider inviting a knowledgeable guest speaker to present on the topic of trauma and abuse. It would be helpful if the presenter also had an understanding of the dynamics of the experience of homelessness. If a guest is invited, alter the time frame for this activity to suit the needs of the presenter and the group.

2. If an outside presenter is not brought in, begin by reading (or inviting volunteers to read) the various poems on the handout. These pieces are compelling statements and provide important insights about the impact of trauma and abuse.

3. Follow the reading of the poems with a presentation and discussion on the topic of trauma and homelessness using your own expertise and drawing from the handout, resource paper, articles, and the various online resources noted above.

4. Inform the group that a whole literature exists on trauma and abuse. Encourage them to read more about this topic and hold discussions with co-workers, perhaps as a work-related "book discussion group." Trauma and Recovery, written by Judith Lewis Herman, is a seminal book on this topic. Additional resources can be found at the websites noted above.

# Entering the Shadows

## *Trauma and Abuse*

### My Grandfather's Eye

My grandfather had one eye.  
All of us kids were fascinated.  
He usually wore a glass eye in the socket,  
but he could pop it out and pass it around  
just like a marble.  
Sometimes he wore a black patch like a pirate.  
Sometimes he just let the barren lid lie there and pulse.

He told us a different story every day  
about how he lost his eye.  
He'd grown up on a farm, after all --  
he told us once a mule had kicked his eye  
right out of his head.  
The next day a pitchfork had poked it out  
during haying season -- that's why  
you don't get careless handling pitchforks and such.  
He'd been a lumberjack -- a falling tree  
had scratched his eye out;  
a flying ember from the cookfire  
fried his eyeball in the socket just like an egg in a pan.  
He used to smoke, and we shouldn't ever --  
he smoked a cigar down too close once  
and burned his own eye out.  
I spent an entire evening  
quietly trying to unpuzzle that one --  
I think that's why he told it to me.

When I was sixteen he told me  
his Dad used to beat him when he drank.  
He used to beat him with a chain.

Anitra F.

### Secret Keeper

I am the keeper of secrets  
to the world on the outer  
I shine and smile brightly  
My appearance does not  
indicate anything other than  
all is right with the world.

But inside there is buried  
anger I haven't even reached yet  
Sometimes the pain is so  
intense I can't breathe

Which man is standing on  
my chest this time, grandfather,  
father, husband, boss, who else?

I thought I left the abuse  
behind. Instead it's buried  
inside -- like Pandora's box --  
once the lid has been removed  
all manner of demons arise.

Madeline L.

### Under Construction

I used to have no trespassing signs all over my body  
Some people don't know the meaning of boundaries  
One day they came busted down my door  
they came in violating code  
they tore up my floors and gutted my soul  
they put a jackhammer through my walls  
and a sledgehammer to my head:  
I have enough yellow police tape to hang myself.

Heidi H.

The Map Is Not The Territory

Eskimos have a hundred words for snow.  
Here in the land that made dysfunctional famous  
we have one word for one thousand realities – depression.

Open your eyes to the faded ceiling  
stare without interest  
fall asleep again

rock on the toilet  
stare at the razor on the sink  
teetering on the edge

walk through a crowd  
stare ahead fixedly  
ignoring all the saw-edged  
whispers of your name

walk through a crowd  
hearing nothing

my bones have turned to concrete  
my flesh bruises itself on them

I do not touch  
I do not taste  
my body is a feather  
anchored in nothing

I will never stop weeping  
I will never cry again  
rock and bone have turned villain  
I am everything that is wrong with Life

Daddy came in at midnight  
it has been midnight ever since

I lost my Daddy to cancer  
I am lost

everything is fine  
and I don't give a damn

I need more than a hundred words.

Anitra F.

Untitled

Trying to get close to my mother was like  
getting close with a vacuum sweeper.  
And being close with my father has been  
being close with a lawn mower.

Catherine H.

*(Poetry by homeless and formerly homeless women)*

# Trauma and Abuse...

## Entering the Shadows

By way of introduction, let us listen to the voices of the poets among us ... in this case, of several homeless and formerly homeless women from the Pacific Northwest.

### My Grandfather's Eye

My grandfather had one eye.  
All of us kids were fascinated.  
He usually wore a glass eye in the socket,  
but he could pop it out and pass it around  
just like a marble.  
Sometimes he wore a black patch like a pirate.  
Sometimes he just let the barren lid lie there and pulse.

He told us a different story every day  
about how he lost his eye.  
He'd grown up on a farm, after all --  
he told us once a mule had kicked his eye  
right out of his head.  
The next day a pitchfork had poked it out  
during haying season -- that's why  
you don't get careless handling pitchforks and such.  
He'd been a lumberjack -- a falling tree  
had scratched his eye out;  
a flying ember from the cookfire  
fried his eyeball in the socket just like an egg in a pan.  
He used to smoke, and we shouldn't ever --  
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and burned his own eye out.  
I spent an entire evening  
quietly trying to unpuzzle that one --  
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When I was sixteen he told me  
his Dad used to beat him when he drank.  
He used to beat him with a chain.

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anger I haven't even reached yet  
Sometimes the pain is so  
intense I can't breathe

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my chest this time, grandfather,  
father, husband, boss, who else?

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Eskimos have a hundred words for snow.  
Here in the land that made dysfunctional famous  
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ignoring all the saw-edged  
whispers of your name

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hearing nothing

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Daddy came in at midnight  
it has been midnight ever since

I lost my Daddy to cancer  
I am lost

everything is fine  
and I don't give a damn

I need more than a hundred words.

Anitra F.

Today we want to speak aloud about and seek to better understand the experiences of those who, in the words of the ancient psalm, have walked "through the valley of the shadow of death," in this case, abuse, trauma and repeated victimization ... a kind of living death!

To do this we must enter into places of shadow. Shadows are the poetry of the visual world. In places of shadow, light is indirect and diffuse. It creates subtleties and grayness. Clarity gives way to mystery. Some things are disguised or hidden. Everything is not necessarily as it appears. In the shadows, we become extra alert, because danger lurks there.

In places of direct and bright light, we observe mostly with the intellect. In the shadows, emotion and soul come to the fore. In addition our language changes. We no longer speak in precise terms. Instead, we speak in poetic metaphors and with stories.

I wish to share a bit of my story as a social worker/mental health practitioner who has been in process of grappling with, naming, and coming to understand the impact of trauma and abuse in the lives of the homeless men and women with whom I work. Perhaps in some way my observations might be instructive and relevant to your experience. I have come to believe that the issue of trauma and abuse is one of the least acknowledged or understood issues in our work, yet has tremendous impact on our provision of care and on the health outcomes of the people we serve.

This past Christmas I received one of those electronic gifts via the Internet from a colleague. It was called a "Santa Stereogram." Upon opening the website, I found myself staring at the computer screen filled with rows and columns of fuzzy little Santa Claus images. Along with the stereogram came viewing instructions which read:

*"To see the hidden three-dimensional stereogram image you must relax your eyes and allow your point of focus to move behind the surface of the screen. It may help to focus on your reflection in the computer screen. When your focus reaches the correct point, the hidden Multi-Dimensional image will come into focus automatically. Important: If you experience any discomfort, stop, rest, and try again later."*

I did as instructed, but could not see the hidden image. Finally, it took a tip from my 13-year-old son to finally see it. When I was able to focus in a new way and found the proper viewing range, there was the hidden message in plain sight. It said: "Ho Ho Ho!"

Looking for what is hidden is the task before each of us as care providers. It is about entering the shadows and coming to understand the behaviors and symptoms of our patients within a new paradigm. It is about moving beyond labels towards the literal meaning of *diagnosis* which is "to know through and through".

As is likely true for you, in recent years I have been noticing a trend towards a much greater complexity of health and behavioral symptoms with which people experiencing homelessness have been presenting. In other words, their "disorders" are more difficult to figure out and harder to treat. Increasingly, I have been encountering so-called "difficult patients." Their symptoms seem to be representative of numerous diagnoses at once, and yet appear to fit none at all! In trying to make sense of this, I sat down and listed the characteristic symptoms I was seeing.

Examples included:

- poor impulse control and judgment
- maladaptive social skills
- intense anger ("I feel like a time-bomb waiting to go off!")
- tendency to externalize blame, or conversely, to blame oneself exclusively
- easily bored
- difficulty sustaining interest or effort (e.g. able to get a job but unable to keep it)
- multiple somatic complaints
- thrill-seeking (with minimal regard for consequences)
- tendency to abuse substances
- unstable moods
- atypical depressive symptoms
- hopeless, feeling numb, disengaged ("I feel like I'm already dead!")
- magical thinking
- poor sense of self, self-worth or self-efficacy
- lack of sense of connectedness/belonging ("feel like a little boy peering through the window of a candy store but can never go inside")
- feel different from everyone else
- tendency to be re-active vs. pro-active
- frequent brushes with the law, anti-social behaviors
- "surviving" in the world, barely living in it

Many of these individuals have been given various diagnoses, not necessarily erroneously, such as atypical depression, rapid-cycling bipolar disorder, impulse control disorder, borderline personality disorder, anti-social personality disorder, and substance abuse disorder. Target symptoms are treated accordingly especially with mood stabilizers, anti-depressants and anti-anxiety agents, typically with modest benefit to the patient.

In addition, treatment is properly focused on social service needs such as access to health care, housing, entitlements, and vocational training. Yet something very significant seems to be missing in the treatment approach, like the proverbial "elephant in the middle of the room." Even the best biological, social and environmental treatments seem to barely impact the individual's deeper sense of self that is often quite unstable and fragile. Psychologically and emotionally, there exists a deep woundedness that requires careful attention.

As a result of extensive reading and dialogue with colleagues, I believe my focus finally "reached the proper point and I saw the hidden image." It seems what these individuals had in common was the experience of having been seriously traumatized, abused and/or neglected, often beginning in early childhood. All of a sudden, it seemed so obvious.

They were the grown children whose personalities had been formed and deformed by being trapped in an abusive environment as children. As Judith Herman states in her seminal book, Trauma and Recovery, that a child in this situation "is faced with formidable tasks of adaptation. She/he must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect oneself, this child must compensate for the failures of adult care and protection with the only means at his/her disposal, an immature system of psychological defenses."

I came to the understanding that I was working with people who were very skilled survivors. If a diagnostic label is required, it seems most useful to find one that speaks to a person's adaptive survival response to extreme, persistent stress. Thus, it has been proposed by Herman and others to call this syndrome "complex post-traumatic stress disorder."

Grappling with the topic of trauma and abuse is an inherently controversial if not a dangerous proposition. For one, it is troubling at a personal level for many. For some, because it stirs up recollections of past personal experiences; for others because of the discomfiting nature of the topic itself. Perhaps more than most issues, it seems to put us in touch with a sense of extreme disorder, if not evil, in the world.

In addition, what we are talking about here is *violence*. Violence holds a curious position in our culture. We abhor it *and* we sanction it. We decry it *and* we depend on it. Witness how readily we condemn certain forms of interpersonal violence (assault, murder), yet easily condone violence inflicted on whole peoples in the name of freedom, safety or defense. Whether by bombing, imposing economic sanctions, disproportionately incarcerating people of color, upholding gender inequalities, failing to control the sale of weapons to our own citizenry or to other governments, continuing policies that keep poor people in poverty, regarding domestic violence as a private matter, and so on, violence is too often justified and legitimized by our culture.

The term violence in essence means “to violate.” To commit violence is to violate the integrity and wholeness of someone or something. It is to intrude upon, control, subjugate, take advantage of, withhold something needed or valued, hold captive, deprive of freedom, keep in isolation, willfully harm, demean, debase or disrespect another. Violence is ultimately relational. It creates brokenness and disorder in our relationships with self, others, and the world. Is this not the violence of abuse?

The topic of violence and abuse is also controversial because it is political, that is to say, it is about people and power. It involves perpetrators and victims (and some who are both). Perpetrators mightily resist being revealed. Thus, they use their power to distort the truth. Because perpetrators rarely appear to the outside world like anything other than normal human beings leading normal or even exemplary lives, the dissonance between their public persona and their abusive characteristics is difficult to reconcile. It is often difficult for survivors to make their truth believable to others in the face of such normalcy.

Of course, many victims also appear quite normal to the outsider. This is an important survival skill. “I shine and smile brightly ... my appearance does not indicate anything other than all is right with the world.” So, “what is the problem?” we ask. “You look like you are doing fine.” However, this appearance of “all is okay” often provides a public mask for much privately held turmoil. As a culture, we tend to regard victims with ambivalence. Our sympathies are usually reserved for those affected by time-limited crises such as those caused by accidents or fires. Our patience runs thin for people who have no visible reasons to be troubled, and yet have difficulty functioning effectively in the world.

Empathy diminishes further when victims refuse to be “good victims,” that is, when they cease the public smiling and they speak up and/or act out the truth of their experience. Thus, they become “difficult.” All too often, scapegoating and blaming the victim soon follows.

Finally, this is a controversial topic because the antidote is not at all easy. It requires time, compassionate people, patience, expertise, multiple resources and money. As H.L. Mencken says: “Every complex problem has a simple solution ... and it’s wrong!”

What we know is that when people have been violated in a pervasive manner especially from childhood, that the difficulties that ensue are woven in deep complexity.

Recovery, which is indeed possible, takes considerable time and must be mediated through nurturing, non-violating relationships. In order for someone to move from surviving to thriving, a therapeutic relationship is integral to the process. Someone needs to provide accompaniment and hold the lantern along the journey. The journey itself involves restoration of a sense of safety, remembering and telling one's story, and reintegrating and reconnecting with the larger community.

The psalm quoted at the beginning of this paper does not end with the writer being stuck in "the valley of the shadow of death." The very next line reads "*I will fear no evil, for you are with me.*" This speaks of the safety, protection and reconnection that can emerge only in relationship.

In closing, it seems to me that our task and challenge as care providers (and as human beings) is to enter into that deeper relationship and walk the journey with people experiencing homelessness and who have experienced trauma and abuse in their lives, even if only in small ways. Providing such a presence is the foundation from which healing and recovery can take hold. It simply takes the courage and willingness to "enter the shadows."

Ken Kraybill, MSW  
Adapted from presentation at  
1999 National HCH Conference  
Washington DC

## **4B: Assessing Client Concerns and Needs**

### **Purpose**

To increase understanding of the nature of assessment in the outreach context and to enhance knowledge and skills to effectively assess individual's level of functioning and need

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **Activity 1 What is assessment?**

Purpose: To explore the meaning and characteristics of assessment in outreach

Time: 20 minutes

Materials: Resource Paper: Outreach and Assessment

Preparation: Review the resource paper and prepare a presentation about assessment as it relates to outreach.

### Procedure:

1. Give a presentation based on the material in the resource paper and your own insights about the meaning and nature of assessment in outreach. Emphasize that assessment is a continuous, multi-layered process that is based on a collaborative effort between worker and client. Note how the focus of assessment changes over time based on current realities and the relational phase that the worker and client have reached. Provide illustrations of the assessment process from your own outreach experience.

2. Facilitate a group discussion about assessment in the outreach context. Some questions to ask might include:

- Why does assessment need to be collaborative in a client-centered approach to outreach? What are specific ways to make it collaborative?
- What is the difference between assessment and a diagnostic label?
- How is the literal meaning of diagnosis (“to know through and through”) related to the meaning of assessment?
- How would you describe the main focus of assessment in each of the phases of the worker-client relationship according to the Relational Outreach and Engagement Model (Approach, Companionship, Partnership, and Mutuality)? Give specific examples.
- Why is it important to avoid jumping to conclusions in assessment and offering help prematurely?
- What are the differences and similarities between understanding someone and helping them?



# Outreach and Assessment

Assessment in the outreach context is a continuous activity that begins upon initial contact with a homeless person and ends only when there is no longer a working relationship between the worker and client. Providers in various clinical settings will sometimes talk about "doing an assessment" as if it were a one-time-only event but there is much more to assessment than gathering data and completing a form. Because people and circumstances are continually changing, assessment and re-assessment is necessarily an on-going process.

The focus of assessment in outreach is determined by the realities of the present situation as well as the relational phase that the worker and homeless person have reached. In the initial *approach* phase, assessment is focused on the individual's basic functioning and his or her capabilities to meet personal safety, survival and basic care needs. In time, as the relationship moves into the *companionship* phase, assessment turns toward the person's needs and wishes for services, professional and non-professional, and assistance in achieving personal goals.

In the *partnership* phase assessment is oriented towards the individual's abilities to work effectively with other providers and beginning to explore and assess his or her intra-personal feelings and perceptions. This exploration continues into the *mutuality* phase and leads towards examination of the individual's sense of identity and personhood, intimacy issues, friendships, family relationships, purpose and meaning, vocation, spirituality, etc.

Assessment in client-centered outreach is a collaborative effort between worker and client, not unilateral. The worker gathers information from the homeless individual's perspective and from the worker's own observations and knowledge. When assessment is approached in this manner, the groundwork is laid for collaboration to naturally occur in the planning and intervention steps to be taken down the road.

Assessment is not unlike putting together a puzzle. It requires laying out the pieces, sorting and organizing them in general categories, and then forming a picture piece by piece. It takes time and concentrated effort.

The assessment process is not to be confused with diagnosis in the narrow way the term is commonly used – as a shorthand description or label. The literal meaning of diagnosis is "to know through and through." Defined in this way, diagnosis and assessment do in fact become one and the same.

To know someone "through and through" suggests taking the time to listen very carefully to that person's story. Otherwise, assessment will be limited in its accuracy and usefulness. While it is relatively easy to assess the obvious – that

someone is wearing inadequate clothing for the weather, or has skin wounds that need attention, or is intoxicated – it is more difficult to come to an understanding of what has brought them to this point in their lives or what hinders them from moving ahead.

Is the individual unaware of help available? Has he or she given up on ever having a better life? Harboring guilt that is too great to even express? Been hurt emotionally once too many times to care anymore? Struggling with inner voices, real or imagined, which denigrate the individual over and over? Too angry to want anybody's caring or help? These are the questions to which workers must seek answers. Such answers can be learned only through a relational approach to assessment.

Thorough assessment requires that we observe not only what is readily apparent, but also what is "hidden." This means seeing with a "third eye" perspective. That is, listening for nuance, noting ambivalence, observing what's missing, paying attention to your own reactions and intuition, and testing out ideas. The "hidden" is the part of the person's story that is revealed as the bond of trust between worker and client grows stronger and stronger.

As outreach workers, we can miss a lot of critical knowledge if we avoid the "hidden" and jump to conclusions in assessment and offer help prematurely. For example, experienced outreach workers know that it can not be assumed that someone living on a river bank in a makeshift tent would rather stay in a mission or public shelter or want permanent housing for that matter. Or, that someone who is feeling ill wants to see a medical provider. Or, that a person who is experiencing depression will be eager to be treated with medications.

Frequently, the deeper psychological and emotional problems that individuals face keep them from resolving their homelessness-related problems of housing, income, and seeking health care and social service assistance. Acknowledging and attempting to address these deep-down issues cannot be ignored if we are to be successful in helping people move from the streets toward greater stability.

In Health Care for the Homeless programs some outreach workers are generalists while others have specialized training in medicine, mental health, addictions or in working with specific populations of homeless people. Therefore, the emphasis or targeting of assessment activities will vary from provider to provider. However, it remains the responsibility of all providers involved in outreach to strive to know individuals "through and through" so as to be accurate in assessment and effective with our interventions.

Ken Kraybill

## **Activity 2 Assessing Mental Status**

Purpose: To enhance participants' knowledge and skills in evaluating a person's mental status, a key part of assessment in outreach

Time: 30-35 minutes

Materials: Handout: Assessing Mental Status

Go to <http://www.psychpage.com/learning/library/assess/mse.htm> on the Internet and print out the information regarding the basic content of a mental status exam and some useful screening questions to ask. Use this as background information for this activity.

### Preparation:

The ability to assess someone's general mental status is a key part of outreach work. The mental status "exam" (MSE) represents an organized way of observing and thinking about various aspects of a person's presentation and overall functioning. It provides the basis for thorough assessment.

Assessing mental status is primarily about being keenly observant. The worker can learn a great deal by simply observing a person's responses in the course of ordinary conversation and by asking a few key questions.

Assessing mental status can be done informally anywhere at anytime. In fact, all people "perform" mini mental status exams all the time in the course of relating to one another. Everyone has a "mental status!"

The emphasis in the outreach context is on incorporating this systematic way of observing into one's daily encounters. Outreach workers will rarely employ a formal, overt exam approach, e.g. asking a client to interpret the meaning of a proverb or to perform serial sevens counting backwards from one hundred. However, workers do need to regularly assess how a person is functioning, keeping a particular eye on deterioration of functioning.

Review the material on the website about how to do a mental status exam. Note that the outline on the handout matches the information on the website.

### Procedure:

1. Give a brief presentation about the importance of assessing mental status in outreach. Base your presentation on the comments in the preparation section above, information from the website, and your own clinical experience. Encourage participants to weave this basic assessment approach routinely into the fabric of their everyday interactions in outreach. Be sure to cover the screening questions from the material on the website to ask to assess for symptoms of depression, anxiety, suicidal or homicidal ideation, compulsions and

obsessions, delusions and hallucinations, substance use disorders, impulsivity, mania, paranoia, etc.

2. Distribute copies of the handout. Review the various components of a mental status exam listed there in as much detail as is needed. Give examples and elicit thoughts from the group on common words and phrases used to describe behavior, thoughts, affect, etc. Utilize case examples as is helpful.

3. Divide the group into pairs and instruct them to carry on a conversation about any topic they wish for about two to three minutes. Participants can "act like themselves" or are welcome to "play-act" being someone else if they wish. During this conversation partners are to carefully note to themselves observations about each other's mental status (e.g. casually dressed, relaxed, averted eye contact, mildly anxious, pressured speech, paranoid ideas, etc.)

4. At the end of the conversation, have each person jot down observations about each other's mental status using the handout as a guide and then share these observations with each other.

5. As the final step in the activity, instruct each partner to role play asking some of the screening questions one might ask to assess further about the presence of depression, anxiety, suicidal or homicidal ideation, compulsions and obsessions, delusions and hallucinations, substance use disorders, impulsivity, mania, paranoia, etc.

# **Assessing Mental Status**

## **Appearance**

Identifying characteristics

Basic grooming and hygiene

Gait and motor coordination

## **Manner and Approach**

Interpersonal behaviors

Behavioral approach

Speech

Eye contact

Expressive language

Receptive language

Recall and memory

## **Orientation, Alertness, and Thought Processes**

Orientation

Alertness

Coherence

Concentration and attention

Thought processes

Hallucinations and delusions

Judgment and insight

Intellectual ability

Abstraction skills

## **Mood and Affect**

Mood or how person feels most days

Affect or how person felt at a given moment

Rapport

Facial and emotional expressions

Suicidal and homicidal ideation

Risk for violence

Impulsivity

Depression

Anxiety

## **Screening Questions For:**

Depression

Anxiety

Compulsions and obsessions

Delusions and hallucinations

Eating disorders

Impulsivity

Mania

Paranoia

(Go to <http://www.psychpage.com/learning/library/assess/mse.htm> for additional information.)

## **Activity 3 Screening and Assessment Tools**

Purpose: To introduce participants to a sample of assessment tools to build upon their knowledge base about assessment activities

Time: 20 minutes

### Materials:

- Intake/assessment tools from participants' own agencies – especially those specific to outreach
- Handout: Cultural Evaluation
- Handout: Global Assessment of Functioning(GAF) Scale
- Handout: Health Care for Homeless Veterans Contact Form
- Children's Global Assessment of Functioning(GAF) Scale  
<http://www.southalabama.edu/nursing/psynp/cgas.pdf>
- Family – Health Screening Questionnaire. Specific to homeless families.  
<http://www.nhchc.org>

Note: Samples of intake/assessment tools used in HCH Projects around the country can be ordered from the Health Care for the Homeless Information Resource Center <http://www.hchirc.com/tools>

### Preparation:

The intent of this activity is to provide participants with information about the similarities and differences of different tools based on program needs, job expectations, and the population being served. It is not necessarily within the scope of this activity to teach participants how to use these tools although facilitators could incorporate such instruction as they wish.

Review the tools and select the ones you plan to use in this activity. If possible, include relevant assessment forms from participant's own agencies. Make copies to be handed out.

### Procedure:

1. Distribute copies of the assessment tools selected for this activity. Explain that the intent of the activity is to introduce participants to various assessment forms used in outreach and to perhaps spark new ideas and ways of doing on-going assessment and re-assessment. Provide a reminder that workers, unless professionally qualified, are not expected to make diagnoses. However, they certainly can make very helpful observations and offer impressions to inform others' decisions about diagnoses.
2. Review each tool with the group, taking time for discussion and responding to questions. Close the activity by encouraging participants to continue to be "active learners" in developing their assessment skills and expanding their breadth of inquiry as needed, e.g., assessing cultural issues more thoroughly.

# Cultural Evaluation

## Language Capabilities and Preferences

- ✓ Language of upbringing
- ✓ Language(s) which the person prefers for speaking to family – speaking with care providers
- ✓ Individual's English language skills
- ✓ Need for translation or interpreter assistance
- ✓ Additional language factors

## Religious Beliefs and Practices

- ✓ Current religious affiliation
- ✓ Religion of upbringing
- ✓ Frequency of prayer/attendance at services
- ✓ Significant religious/spiritual beliefs, practices, or experiences
- ✓ If the individual has consulted a religious leader/healer regarding health-related concerns, what recommendations were made and their impact
- ✓ Additional religious/spiritual factors

## Acculturation Issues

- ✓ Number of generations family has been in the United States
- ✓ Ethnicity of significant others
- ✓ Person's self-perceived cultural identity
- ✓ Additional acculturation issues

## Migration History

- ✓ Place of birth
- ✓ Length of time in United States
- ✓ Environment in native country (rural, city, suburban)
- ✓ Individual's or family's socioeconomic status in native country
- ✓ Reasons/circumstances for migration
- ✓ If person currently visits native country, indicate reasons and frequency
- ✓ Attitude of native country/region towards health/mental health/substance use issues
- ✓ Additional migration issues

## Family Structure

- ✓ Effect of migration or separation on the family structure
- ✓ Role of extended family in person's life
- ✓ Additional family structure issues

(Adapted from "Cultural Evaluation" form, State of New York, Office of Mental Health)



## Global Assessment of Functioning (GAF) Scale\*

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate e.g. 45, 68, 72.)

91–100 Superior functioning in a wide range of activities. Life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81-90 Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members)

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)

61-70 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

31-40 Some impairment in reality testing or communication (e.g. speech is at all times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking or mood (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

21-30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home, or friends).

11-20 Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).

1-10 Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information.

\* Table from DSM-IV, American Psychiatric Association, Washington, 1994.

HEALTH CARE FOR HOMELESS VETERANS

CONTACT FORM

Page 1 of 5

Staff Member's Name \_\_\_\_\_ (3)  
*Office Use Only DO NOT CODE* \_\_\_\_\_

Date of Intake (mm, dd, yy)..... \_ \_ / \_ \_ / \_ \_ (9)

VA Facility Code..... \_ \_ \_ \_ \_ (12)

**I. VETERAN DESCRIPTION**

1. Veteran's Name (last name, first initial) (please print) \_\_\_\_\_ (32)
2. Social Security Number..... \_ \_ - \_ - \_ \_ \_ (41)
3. Date of Birth (mm/dd/yy)..... \_ \_ / \_ \_ / \_ \_ (47)
4. Sex.....  1. Male  2. Female (48)
5. Ethnicity (check only one) (49)
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 1. Hispanic, white            | <input type="checkbox"/> 4. Black, not Hispanic | <input type="checkbox"/> 7. Pacific Islander |
| <input type="checkbox"/> 2. Hispanic, black            | <input type="checkbox"/> 5. Asian               | <input type="checkbox"/> 8. Other            |
| <input type="checkbox"/> 3. American Indian or Alaskan | <input type="checkbox"/> 6. White, not Hispanic |  |
6. What is your current marital status (check only one)? (50)
- |                                       |                                       |   |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> 1. Married   | <input type="checkbox"/> 3. Widowed   | <input type="checkbox"/> 5. Divorced      |
| <input type="checkbox"/> 2. Remarried | <input type="checkbox"/> 4. Separated | <input type="checkbox"/> 6. Never Married |

**CONTACT WITH VETERAN**

- Where did this interview take place (check only one)?
- |   |  |      |
|---|--|------|
| <input type="checkbox"/> 1. Shelter or temporary housing for homeless | <input type="checkbox"/> 6.* At special program for homeless (Specify) _____ | (51) |
| <input type="checkbox"/> 2. Street, Park, Outdoors                    | <input type="checkbox"/> 7. Prison or jail                                   |      |
| <input type="checkbox"/> 3. Soup Kitchen                              | <input type="checkbox"/> 8. Other  |      |
| <input type="checkbox"/> 4. VAMC                                      |  |      |
| <input type="checkbox"/> 5. Vet Center                                |  |      |

*Office Use Only DO NOT CODE* \_\_\_\_\_ (54)

- How was contact with this program initiated (check only one)?
- |   |  |      |
|---|--|------|
| <input type="checkbox"/> 1. Outreach initiated by VA staff  | <input type="checkbox"/> 5. Veteran came to Vet Center   | (55) |
| <input type="checkbox"/> 2. Referred by shelter staff or other non-VA staff working in a program for the homeless | <input type="checkbox"/> 6. Self-referred  |      |
| <input type="checkbox"/> 3. Referral from VAMC inpatient unit   | <input type="checkbox"/> 7.* Through VA presence at special program for homeless (specify) _____ |      |
| <input type="checkbox"/> 4. Referral from VAMC outpatient unit  | <input type="checkbox"/> 8. Other  |      |

*Office Use Only DO NOT CODE* \_\_\_\_\_ (58)

- Veteran response to contact (check only one)?
- |  |   |      |
|--|---|------|
| <input type="checkbox"/> 1. Would not talk to VA staff             | <input type="checkbox"/> 4. Is interested in full range of VA services for the homeless | (59) |
| <input type="checkbox"/> 2. Talked; not interested in any services | <input type="checkbox"/> 5. Other   |      |
| <input type="checkbox"/> 3. Only interested in basic services      |   |      |

\* Do not use this category unless the specific program has been officially identified a special program for the homeless by VA's Northeast Program Evaluation Center.

**II. MILITARY HISTORY**

7. Period of Service (*check longest one*)? (60)
- |   |   |  |      |
|---|---|--|------|
| <input type="checkbox"/> 1. Pre-WW II (11/18-11/41) | <input type="checkbox"/> 4. Korean War (7/50-1/55)                      | <input type="checkbox"/> 7. Post-Vietnam (5/75-7/90) | (60) |
| <input type="checkbox"/> 2. WW II (12/41-12/46)     | <input type="checkbox"/> 5. Between Korean and Vietnam Eras (2/55-7/64) | <input type="checkbox"/> 8. Persian Gulf (8/90-)     |      |
| <input type="checkbox"/> 3. Pre-Korean (1/47-6/50)  | <input type="checkbox"/> 6. Vietnam Era (8/64-4/75)                     |  |      |
8. Did you ever receive hostile or friendly fire in a combat zone?  0= No  1=Yes (61)

**III. LIVING SITUATION**

9. Where did you sleep last night? (*check only one*) (62)
- |  |  |      |
|--|--|------|
| <input type="checkbox"/> 1. Own apartment, room or house                         | <input type="checkbox"/> 4. No residence (e.g., outdoors, abandoned building)      | (62) |
| <input type="checkbox"/> 2. Apartment, room or house of family member or friend  | <input type="checkbox"/> 5. Institution (hospital, residential treatment facility) |      |
| <input type="checkbox"/> 3. Shelter/Temporary Housing Program (no or minimal tx) | <input type="checkbox"/> 6. Prison or jail   |      |
10. How long have you been homeless? (*check only one*) (63)
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 0. Not currently homeless                     | <input type="checkbox"/> 3. At least 6 months but less than 1 year  |  |
| <input type="checkbox"/> 1. At least one night but less than one month | <input type="checkbox"/> 4. At least one year but less than 2 years |  |
| <input type="checkbox"/> 2. At least one month but less than 6 months  | <input type="checkbox"/> 5. Two years or more                       |  |
|  | <input type="checkbox"/> 6. Unknown                                 |  |

11. During the past 30 days (1 month), how many days did you sleep in the following kinds of places? (*Note: Estimates may often be necessary here. In such cases, make sure the number of days adds up to 30*)
- |   |       |      |
|---|-------|------|
| a. Own apartment, room or house.....  | __ __ | (65) |
| b. Someone else's apartment, room or house.....                                     | __ __ | (67) |
| c. Hospital or nursing home (include detox centers with medical staff on site)..... | __ __ | (69) |
| d. Domiciliary.....   | __ __ | (71) |
| e. VA contracted halfway house programs (ATU-HWH or HCHV contract).....             | __ __ | (73) |
| f. Non-VA halfway house program.....  | __ __ | (75) |
| g. Hotel, Single Room Occupancy (SRO), boarding home.....                           | __ __ | (77) |
| h. Shelter for the homeless (including detox centers with no medical staff on-site) | __ __ | (79) |
| i. Outdoors (sidewalk, park), abandoned building.....                               | __ __ | (81) |
| j. Automobile, truck, boat.....   | __ __ | (83) |
| k. Prison, jail.....  | __ __ | (85) |

**IV. MEDICAL**

12. Do you feel you have any serious medical problems (*veteran's perception*)?.....  0= No  1=Yes (86)
13. Does the veteran have or has the veteran complained of any of the following medical problems (*check one box for each question*)?
- |   |   |      |
|---|---|------|
| a. Oral/dental problems.....              | <input type="checkbox"/> 0= No <input type="checkbox"/> 1=Yes | (87) |
| b. Eye problems (other than glasses)..... | <input type="checkbox"/> 0= No <input type="checkbox"/> 1=Yes | (88) |

- c. Hypertension.....  0= No  1=Yes (89)
- d. Heart or cardiovascular problems.....  0= No  1=Yes (90)
- e. COPD/emphysema.....  0= No  1=Yes (91)
- f. TB.....  0= No  1=Yes (92)
- g. Gastrointestinal problems.....  0= No  1=Yes (93)
- h. Liver disease.....  0= No  1=Yes (94)
- i. Seizure disorder.....  0= No  1=Yes (95)
- j. Orthopedic problems.....  0= No  1=Yes (96)
- k. Significant skin problems.....  0= No  1=Yes (97)
- l. Significant trauma.....  0= No  1=Yes (98)
- m. Other .....  0= No  1=Yes (99)  
 (specify) \_\_\_\_\_

Office Use Only DO NOT CODE \_\_\_\_\_ (101)

**V. SUBSTANCE ABUSE**

- 14. Do you have a problem with alcohol dependency now (*veteran's perception*)?...  0= No  1=Yes (102)
- 15. Have you had a problem with alcohol dependency in the past?.....  0= No  1=Yes (103)
- 16. Have you ever been hospitalized for treatment of alcoholism?.....  0= No  1=Yes (104)
- 17. During the past 30 days, how many days would you say that you used any alcohol at all? (*If none, skip to number 18*)..... -- -- (106)
- 17a. During the past 30 days, how many days would you say that you drank to intoxication?..... -- -- (108)
- 18. Do you have a problem with drug dependency now (*veteran's perception*)?.....  0= No  1=Yes (109)
- 19. Have you had a problem with drug dependency in the past?.....  0= No  1=Yes (110)
- 20. Have you ever been in a residential treatment program or hospitalized for treatment of drug dependency?.....  0= No  1=Yes (111)
- 21. During the past 30 days, how many days would you say that you used any other drugs, such as heroin or methadone; barbiturates (downers); cocaine or crack; amphetamines (speed); hallucinogens, like acid; or inhalants, like glue or nitrous oxide? (*If none, skip to number 23*)..... -- -- (113)
- 22. During the past 30 days, how many days would you say you used more than one kind of drug?..... -- -- (115)

**VI. PSYCHIATRIC STATUS**

23. Do you think that you have any current psychiatric or emotional problem(s) other than alcohol or drug use?.....  0= No  1=Yes (116)
24. Have you ever been hospitalized for a psychiatric problem (*Do not include substance abuse treatment*)?.....  0= No  1=Yes (117)
25. Have you used the VA medical system for medical and/or psychiatric care in the past 6 months?.....  0= No  1=Yes (118)
26. Now I'm going to ask you about some psychological or emotional problems you might have had in the past 30 days. You can just say "yes" or "no" for these. During the past 30 days, have you had a period (that was not the direct result of alcohol or drug use) in which you... (*Check one answer for each item; blank responses will not be considered a "no" response*)
- a. experienced a serious depression.....  0= No  1=Yes (119)
- b. experienced serious anxiety or tension.....  0= No  1=Yes (120)
- c. experienced hallucinations.....  0= No  1=Yes (121)
- d. experienced trouble understanding, concentrating, or remembering.....  0= No  1=Yes (122)
- e. had trouble controlling violent behavior.....  0= No  1=Yes (123)
- f. had serious thoughts of suicide.....  0= No  1=Yes (124)
- g. attempted suicide.....  0= No  1=Yes (125)
- h. took prescribed medication for a psychological/emotional problem.....  0= No  1=Yes (126)

**VII. EMPLOYMENT STATUS**

27. Which best describes your employment pattern in the past 3 years? (*check only one*) (127)
- |   |  |
|---|--|
| <input type="checkbox"/> 1. Full time (40 hrs/wk)         | <input type="checkbox"/> 5. Student              |
| <input type="checkbox"/> 2. Full time (irregular)         | <input type="checkbox"/> 6. Service              |
| <input type="checkbox"/> 3. Part time (regular hours)     | <input type="checkbox"/> 7. Retired / disability |
| <input type="checkbox"/> 4. Part time (irregular daywork) | <input type="checkbox"/> 8. Unemployed           |
28. How many days did you work for pay in the past 30 days?      \_ \_      (129)
- 29-33. Do you receive any of the following kinds of public financial support (*check one box for each question*)?
29. Service Connected/Psychiatry.....  0= No  1=Yes (130)
30. Service Connected/Other.....  0= No  1=Yes (131)
31. NSC pension.....  0= No  1=Yes (132)

32. Non-VA disability (eg SSDI).....  0= No  1=Yes (133)

33. Other public support (including cash and inkind services).....  0= No  1=Yes (134)

34. Overall, how much money did you receive in the past thirty days from all sources of income: work, disability payments, panhandling, plasma donations etc.)? (check only one) (135)

<input type="checkbox"/> 1. No income at all	<input type="checkbox"/> 4. \$100-\$499
<input type="checkbox"/> 2. \$1-\$49	<input type="checkbox"/> 5. \$500-\$999
<input type="checkbox"/> 3. \$50-\$99	<input type="checkbox"/> 6. \$1000 or more

**VIII. INTERVIEWER OBSERVATIONS**

35. Does this veteran need psychiatric or substance abuse treatment at this time?  0= No  1=Yes (136)

36. Does this veteran need medical treatment at this time?.....  0= No  1=Yes (137)

37-45. Which of the following psychiatric diagnoses apply to this veteran (check one box for each question)?

- 37. Alcohol Abuse/Dependency.....  0= No  1=Yes (138)
- 38. Drug Abuse/Dependency.....  0= No  1=Yes (139)
- 39. Schizophrenia.....  0= No  1=Yes (140)
- 40. Other Psychotic Disorder.....  0= No  1=Yes (141)
- 41. Mood Disorder.....  0= No  1=Yes (142)
- 42. Personality Disorder (DSM-IV Axis 2).....  0= No  1=Yes (143)
- 43. PTSD from Combat.....  0= No  1=Yes (144)
- 44. Adjustment Disorder.....  0= No  1=Yes (145)
- 45. Other Psychiatric Disorder.....  0= No  1=Yes (146)

49-60. What are your immediate plans for referral or treatment of the veteran at this time (check one box for each question)?

- 49. Basic services (food, shelter, clothing and financial assistance).....  0= No  1=Yes (147)
- 50. VA medical services.....  0= No  1=Yes (148)
- 51. Non-VA medical services.....  0= No  1=Yes (149)
- 52. VA psychiatric or substance abuse services.....  0= No  1=Yes (150)
- 53. Non-VA psychiatric or substance abuse services.....  0= No  1=Yes (151)
- 54. VA pension or disability application.....  0= No  1=Yes (152)
- 55. Contract residential treatment through HCHV program.....  0= No  1=Yes (153)
- 56. VA Domiciliary Program.....  0= No  1=Yes (154)
- 57. Upgrading of military discharge.....  0= No  1=Yes (155)
- 58. Legal assistance.....  0= No  1=Yes (156)
- 59. Social vocational assistance.....  0= No  1=Yes (157)
- 60. Other (including HUD-VASH and Grant and Per Diem).....  0= No  1=Yes (158)

(159)

# 4C: Prevalent Health and Related Concerns in Outreach

*Health, Mental Health,  
Substance Use, Violence,  
and Social Justice*

## **Purpose**

To provide an overview of the prevalent health, mental health, substance use, violence, and social justice-related issues that outreach workers encounter in their work with people experiencing homelessness

## **Recommendations for Instructors**

This section is structured quite differently from others in this curriculum. In this section, a menu of resources about prevalent health and related topics in outreach are listed under the Resources heading below. This list is intended to provide a sampling of relevant resources but by no means is comprehensive.

As a training approach, it is suggested that facilitators initially confer with participants in the training group to determine which topics listed are of most interest or relevance to them. The facilitator and group will also need to decide the amount of time to devote to selected topics and how in-depth to cover them. It might be useful to provide training about various topics over time as part of an on-going in-service training plan.

It is highly recommended to bring in colleagues and guest presenters to provide training in regard to clinical issues and topics about which they have particular expertise. For example, a substance abuse counselor might be invited to talk about addictions among homeless people, or a domestic violence expert asked to make a presentation about interpersonal violence, or a medical provider about certain physical health related topics.

There are no individual activities outlined in this section. Instead, the training activity for each topic is to be designed by the presenter. Encourage presenters to use an interactive teaching style with opportunities for discussion and practice or role-playing.

Below is a proposed outline for presenters to use in organizing the content of their training:

- Definition/description of the condition
- Causal factors
- Impact of homelessness/extreme poverty on the condition

- Common signs and symptoms of which outreach workers should be aware
- Basic observations to make and assessment questions for outreach workers to ask
- Tips for health promotion in this particular area
- Local treatment/education/advocacy/support resources
- Suggested reading or other resources for outreach workers to increase their knowledge of the topic

## **Introduction**

Homeless people suffer disproportionately from a myriad of problems, conditions, illnesses, disorders, disabilities, and injustices. The reasons are many and are inextricably interwoven. As James Wright, sociology professor at Tulane University, describes it:

"At varying levels of analysis, homelessness is a housing problem, an employment problem, a demographic problem, a problem of social disaffiliation, a mental health problem, a substance abuse problem, a family violence problem, a problem created by cutbacks in social welfare spending, a problem resulting from the decay of the traditional nuclear family, and a problem intimately connected to the recent increase in persons living below the poverty level, as well as others."

Outreach workers are not expected to "know everything about everything" but do need to have some familiarity and working knowledge in many areas. Of course, this knowledge cannot be attained in one fell swoop. It takes time and comes with experience. The intent of this section is to provide a sampling of resources about some of the issues most relevant to homeless outreach.

It is especially important for outreach workers to possess broad-based knowledge of health and related concerns in order to assess homeless people's conditions and situations accurately and appropriately. Some workers may be highly trained to assess physical health problems, but may be less skilled in assessing substance use disorders or domestic violence. Others may be very familiar with various forms of discrimination that homeless people face but may need some basic knowledge about common skin disorders.

Hopefully all workers, regardless of level of formal training, will commit themselves always to be "students" in regard to the whole spectrum of concerns related to homelessness.



# RESOURCES

## Health and Homelessness

“Balancing Act: Clinical Practices That Respond to the Needs of Homeless People” by Marsha McMurray-Avila, Lillian Gelberg, William R. Breakey  
<http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm>

Centers for Disease Prevention and Control – Health Topics A-Z  
<http://www.cdc.gov/health/diseases.htm>

Delivering Health Care to Homeless Persons, edited by David Wood, Springer Publishing, NY, 1992

Health Care for the Homeless Clinicians' Network  
<http://www.nhchc.org/network.html>

Health Care for the Homeless Information Resource Center  
<http://www.hchirc.com/>

The Health Care of Homeless Persons: A Practical Guide for Clinicians and Shelter Workers (projected completion Summer 2002)

“Health of the Homeless: Definition of Problem” (Chapter 1) by Lillian Gelberg in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

National Health Care for the Homeless Council <http://www.nhchc.org/>

Organizing Health Services for Homeless People: A Practical Guide. Marsha McMurray-Avila. Soft cover, 348 pages. Revised Edition, 2001

“Patient-Oriented Approach to Providing Care to Homeless Persons” (Chapter 2) by Paul Koegel and Lillian Gelberg in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

## Homeless Populations

### Families

Resource Paper: “Domestic Violence and the Family” by Peter Sherman

Health Care for Homeless Children  
<http://www.nhchc.org/hands/1998/oct/octhands.html>

Resource Paper: "Homelessness and the Family" by Irwin Redliner and Peter Sherman

"Mental Health Considerations in Homeless Families: Intake, Diagnoses, and Treatment" by J. Jubelier in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

### **Rural Homelessness**

"Hard to Reach: Rural Homelessness and Health Care" by Patrician Post  
<http://www.nhchc.org/RuralHomeless.pdf>

### **Veterans**

"Homeless Veterans and Health Care: A Resource Guide for Providers" by Marsha McMurray-Avila <http://www.nhchc.org/HomelessVetsHealthCare.pdf>

### **Women**

Women's Health Care: Show Me the Way to Go Home  
<http://www.nhchc.org/hands/2000/aug/aughands.html>

### **Pregnant and Homeless**

<http://www.nhchc.org/hands/2001/August2001HealingHands.pdf>

"Health Concerns of Homeless Women" (Chapter 9) in Under the Safety Net by Philip Brickner, et al. 1990

The National Women's Health Information Center <http://www.4woman.gov/>

### **Youth**

"Medical Care of Homeless and Runaway Adolescents by J. Garshman, C Sanders, G. Yates, and R MacKenzie in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Protecting the Mental Health of Homeless Children and Youth  
<http://www.nhchc.org/hands/2000/feb/febhands.html>

"Understanding the Health Care Needs of Homeless Youth" BPHC Program Assistance Letter (PAL) 2001-10 <ftp://ftp.hrsa.gov/bphc/docs/2001pals/2001-10.pdf>

### **Social Justice**

"Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid" by Patricia Post <http://www.nhchc.org/CasualtiesofComplexity.pdf>

The HCH Mobilizer <http://www.nhchc.org/mobilizer/mobilizer.html>

HCH Policy Papers (updated annually) <http://www.nhchc.org/policy.html>

National Coalition for the Homeless [www.nationalhomeless.org](http://www.nationalhomeless.org)

## Physical Health

Asthma, COPD and Homelessness

<http://www.nhchc.org/hands/1999/jan/janhands.html>

PowerPoint slideshow/game – This is “Communicable Disease” Jeopardy! by Heather Barr

Diabetes and Homelessness

<http://www.nhchc.org/hands/1999/oct/octhands.html>

Diabetes and Homelessness: Overcoming Barriers to Care by Ardyce Ridolfo and Brenda Proffitt <http://www.nhchc.org/clinical.html#Diabetes>

Diabetes Frequently Asked Questions (FAQ's) - National Center for Chronic Disease Prevention and Health Promotion <http://www.cdc.gov/diabetes/faqs.htm>

Chronic Hepatitis C and Homelessness

<http://www.nhchc.org/hands/1999/mar/marhands.html>

Hepatitis C: Interactive training course for clinicians

[http://www.cdc.gov/ncidod/diseases/hepatitis/C\\_Training/edu/default.htm](http://www.cdc.gov/ncidod/diseases/hepatitis/C_Training/edu/default.htm)

HIV/AIDS and Homelessness

<http://www.nhchc.org/hands/1998/sept/septhands.html>

“HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy” by Dr. John Y. Song.

“Human Immunodeficiency Virus and Homeless Persons” by Robin K. Avery and James J. O’Connell in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Hypertension and Homelessness

<http://www.nhchc.org/hands/2001/April2001HealingHands.PDF>

“Hypothermia and Exposure Among Homeless Persons” by J. Lockyer in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

“Skin Diseases of the Homeless” by Richard Usatine in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Tuberculosis and Homelessness

<http://www.nhchc.org/hands/1999/jan/janhands.html>

Combatting Tuberculosis & Homelessness: Recommendations for Policy & Practice <http://www.nhchc.org/clinical.html>

Web-Based Self-Study Modules on Tuberculosis

<http://www.phppo.cdc.gov/phtn/tbmodules/Default.htm>

“Tuberculosis in the Homeless” by C. Panosian in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

## **Substance Use and Mental Health**

“Alcoholism and Substance Abuse” (Chapter 13) in Under the Safety Net by Philip Brickner, et al. 1990

“Assessment and Treatment of Homeless Mentally Ill Adults” by P. Koegel and D. Sherman in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Dual Diagnosis and Homelessness

<http://www.nhchc.org/hands/1998/july/julyhands.html>

“Mental Health Considerations in Homeless Families: Intake, Diagnoses, and Treatment” by J. Jubelier in Delivering Health Care to Homeless Persons, edited by David Wood, 1992

Mental Health of Homeless Children and Youth

<http://www.nhchc.org/hands/2000/feb/febhands.html>

Mental Help Net – a comprehensive source of online mental health information, news and resources <http://www.mentalhelp.net/>

Mental Illness and Chronic Homelessness

<http://www.nhchc.org/hands/2000/October2000HealingHands.PDF>

National Resource Center on Homelessness and Mental Illness

<http://www.nrchmi.com/>

Projects for Assistance in Transition from Homelessness (PATH)

<http://www.pathprogram.com/>

Protecting the Mental Health of Homeless Children and Youth  
<http://www.nhchc.org/hands/2000/feb/febhands.html>

Substance Abuse and Mental Health Administration (SAMSHA), Center for  
Mental Health Services (CMHS), Knowledge Exchange Network (KEN)  
<http://www.mentalhealth.org/>

Substance Abuse Resource Guide: Lesbian, Gay, Bisexual and Transgender  
Populations <http://www.health.org/referrals/resguides.asp?InvNum=MS489>

Handout: Suggestions for Interacting with a Person who is Intoxicated

Handout: Suggestions for Relating to a Person Experiencing Mental Illness

## **Violence and Trauma**

Resource Paper: "Domestic Violence and the Family" by Peter Sherman

Identifying and Responding to Violence among Poor and Homeless Women from  
the Better Homes Fund in collaboration with the HCH Clinicians' Network  
<http://www.nhchc.org/domviolence.html>

National Women's Health Information Center <http://www.4woman.gov/>

Trauma and Homelessness  
<http://www.nhchc.org/hands/1999/apr/aprhands.html>

"Trauma and Victimization" by Susan Fleischman in Delivering Health Care to  
Homeless Persons, edited by David Wood, 1992

## **Suggestions for Interacting with A Person who is Intoxicated**

- ◆ Approach with care; respect the individual's personal space.
- ◆ Use a gentle, soft-spoken voice and body language that communicates to the person "you are safe."
- ◆ Make clear, brief statements. Focus on the here and now.
- ◆ Always respect the person; don't belittle or "put down" the individual; use humor, but not at the person's expense.
- ◆ Take care with responses to provocative statements; stay calm; avoid getting into a confrontation or caught up in the person's "negative energy."
- ◆ Avoid labeling the person as an "alcoholic" or "drug addict" or causing the person to feel guilty or "bad."
- ◆ Empathize with the person's pain, anger or fear; work to disarm the fear and calm the "fight or flight" responses.
- ◆ Give the person time to process; repeat yourself if necessary.
- ◆ Check on the person's immediate physical health and safety; an intoxicated person may be physically ill or injured but unaware of it.
- ◆ Offer immediate, concrete help, e.g. detox, safe space, sleep-off, medical attention.
- ◆ If a person is intoxicated and talking about suicide, do not leave him or her alone. Call or send someone for help, e.g. crisis team, police.
- ◆ Be aware and cautious of how you are affecting the person; leave the situation if the person is becoming increasingly agitated or behaviorally inappropriate.
- ◆ Validate the person; recognize with them what is going on, what the person is going through; hear the person out; listen for the motive the individual has to take a healthy or appropriate step.
- ◆ If possible, follow-up with the person in the near future when they are not under the influence of alcohol or drugs.

*Adapted from conversations with HCH outreach workers*

## **Suggestions for Relating to a Person Experiencing Mental Illness**

- Treat the person with respect, as directly and naturally as possible.
- Speak softly, slowly and clearly, communicating only one thought at a time.
- Be as consistent and predictable as you can.
- Set clear and realistic rules, limits and expectations.
- Set simple, short-term goals based on current abilities.
- Criticize as little as possible; praise what you can.
- Remember the person's perceptions may be different from yours.
- Don't try to argue against voices or delusions; they are symptoms of the illness.
- Allow the person a "comfort zone"; don't stare at, hover over, or press the person. Allow him/her an easy exit.
- Don't take the individual's unreasonable attitudes and behavior personally.
- Don't blame the person or others for the illness.
- Accept the reality of the illness, while appreciating the person as he/she is in the present.
- Maintain your own mental health and well being: seek counseling, join a support group, educate yourself and advocate for positive change, maintain contact beyond your work with friends and enjoyable activities.

## 4D: PERSPECTIVES ON CHANGE IN OUTREACH

“They say you can lead a horse to water, but you can't make him drink.  
But I say, you can salt the oats.”  
– Madeline Hunter

“Habit is habit, and not to be flung out of the window ...  
but coaxed downstairs a step at a time.”  
– Mark Twain

### **Purpose**

To help participants understand the basic principles of how people change and to learn effective approaches to motivate people experiencing homelessness to make decisions to change.

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.



## **Introduction**

How do outreach workers understand the need for behavioral change in the context of relentless poverty and homelessness? How do we deal with personal conditions and disorders so severe and chronic that the prospect of change seems all but hopeless?

Outreach workers go out on the streets and into shelters to make connections with people experiencing homelessness in order to help them better their lives and living situations. The ultimate hope is that their homelessness will be ended and they might be restored in body, mind, and spirit.

Workers offer help by reaching out, listening, providing material assistance, assessing, and attempting to prompt others to make change efforts towards certain goals. They aid this process by providing access to the necessary resources and support to do so. These changes may be as small as persuading someone to accept a cup of coffee or as significant as facilitating someone's entry into treatment for an addiction.

Central to the role of the outreach worker is to be an "agent of change." Workers are like modern day peddlers who, instead of selling shoes and toothbrushes, "sell" the possibilities and opportunities for homeless people to improve their lives. Of course, as experienced workers know, this can be a hard sell especially given the multiple systemic barriers and personal vulnerabilities that interfere with transitioning from the street to stability.

There is an old adage that you can lead a horse to water but you can't make it drink. This is indeed true, despite our human tendency to persist otherwise. It is this notion of "leading to water" that is fundamental to outreach work. Workers do this by conveying empathy, proving themselves to be trustworthy and demonstrating that they have the ability and expertise to help.

In addition it is the function of effective outreach to help create favorable conditions for clients to move in the direction of change and to fully support those efforts. Madeline Hunter, author, adds this twist to the adage: "They say you can lead a horse to water, but you can't make him drink. But I say, you can salt the oats." Outreach workers in fact do what they can within the relationship and through advocacy efforts to "salt the oats" so as to promote client change and use of needed resources.

People who experience chronic homelessness face daunting obstacles in their quest to change and improve their lives. Often there are significant internal emotional and psychological hurdles to be overcome. Deep fears, mistrust, and a lack of self-efficacy related to past experiences are often present. Some people have essentially given up all hope.

In addition, a lack of available and/or appropriate external resources such as

Various social and psychological theories have been put forth as to why and how people change. What they seem to have in common is that certain conditions must be met for people to decide to change their behaviors, attitudes or beliefs. Human beings don't embrace change readily. In fact, we tend to resist it, even when change seems to be in our best interests.

Martin Fishbein, in *Developing Effective Behavior Change Interventions*, suggests that across these theories there appear to be common variables that underlie one's ability to initiate and sustain change efforts. He states that "generally speaking, it appears that in order for a person to perform a given behavior one or more of the following must be true:

- The person must have formed a strong positive intention (or made a commitment) to perform the behavior;
- There are no environmental constraints that make it impossible to perform the behavior;
- The person has the skills necessary to perform that behavior;
- The person believes that the advantages (benefits, anticipated positive outcomes) of performing the behavior outweigh the disadvantages (costs, anticipated negative outcomes);
- The person perceives more social (normative) pressure to perform the behavior than to not perform the behavior;
- The person perceives that performance of the behavior is more consistent than inconsistent with his or her self-image, or that it's performance does not violate personal standards that activate negative self-actions;
- The person's emotional reaction to performing the behavior is more positive than negative; and
- The person perceives that he or she has the capabilities to perform the behavior under a number of different circumstances ..."

Considering these variables, it is not surprising that people facing unremitting poverty, homelessness, and illness often find it difficult to initiate and sustain changes in their lives. And yet, many do succeed in making positive changes.

In this module we will examine three distinct but interconnected change concepts that have been found to be particularly relevant and useful in the Health Care for the Homeless approach to care.

- The **Stages of Change** model provides a framework to understand the change process on a continuum (or spiral).
- **Motivational Interviewing** is a client-centered, directive approach focused on resolving ambivalence in the direction of change.
- **Harm Reduction** is a client-centered approach that recognizes that change is often incremental and that any positive change which results in reducing the negative impact of a behavior is seen as significant.

## **ACTIVITY 1 Motivating Change in Outreach**

*Note: Activity 1 provides an overview of all three change concepts. Activities 2, 3 and 4 focus on each change concept in greater detail.*

Purpose: To provide an overview of three change concepts – stages of change, motivational interviewing, and harm reduction – and their relevance and application to outreach with people experiencing homelessness

Time: 60 minutes

Materials:

Handout: Motivating Change in Outreach (Download the PowerPoint presentation, Motivating Change in Outreach, and print out six slides per page = total 8 pages)

Optional: Additional selected handouts from Activities 2, 3 and 4 below

Optional: LCD projector, projection screen, downloaded PowerPoint presentation from laptop computer or overhead projector with transparencies of individual slides

Preparation: Download and preview the PowerPoint (PP) presentation or review the handout that contains printed copies of the presentation slides. Choose the method by which you will make this presentation. Options include:

- 1) download the PP slides and use an LCD projector and screen
- 2) use overhead projector in which case you will need to make transparencies/overheads for each slide
- 3) use printed copies of the slides only.

Whichever method you use, plan to provide a handout of the PowerPoint slides to each participant.

Prepare notes and illustrations for your presentation. It may be useful to review the handouts and resources listed in Activities 2, 3, and 4 in this section for background information. In addition, books such as Motivational Interviewing by Miller & Rollnick and Changing for Good by Prochaska, Norcross and DiClemente are valuable to read. Also, you might browse the Internet for additional information about these change concepts.

Procedure:

1. Make a presentation to the group using the slides/transparencies/handouts as a basis for your teaching. Use illustrations as much as possible. Invite participants' questions and comments.

It is recommended that you devote time during this presentation or some other time to practice some of the basic skills of motivational interviewing as outlined in the OARS handout: **O**pen-ended questions, **A**ffirmations, **R**eflective listening, and **S**ummaries. See Module 3 Listening with All Six Senses for practice activities specific to reflective listening and summarizing.

Building Trust, Instilling Hope,  
**Motivating Change  
in Outreach**  
with People Experiencing Homelessness

Ken Kraybill, MSW  
National Health Care for the Homeless Council  
HCH Clinicians' Network  
<kkraybill@nhhc.org>

1

**CHANGE ...**

*"It Don't Come Easy"*

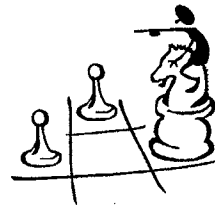


2

*"Given a choice between changing  
and proving that it is not  
necessary, most people get busy  
with the proof."*

John Galbraith

3



*People always use their best  
problem-solving strategies to get  
their needs met, even if these  
strategies are dysfunctional.*

4

*"What challenges do  
people experiencing  
homelessness face in trying  
to better their lives?"*

5

## **Realities and Experience of Homelessness**

### Structural Barriers

- Lack of adequate income support/a livable wage
- Lack of appropriate, affordable housing
- Lack of access to health/mental health/substance abuse care
- Inadequate social supports

6

## Realities and Experience of Homelessness

### Personal Vulnerabilities

- Physical health problems
- Mental disorders
- Substance use disorders
- Trauma and abuse/domestic violence

7

## Realities and Experience of Homelessness

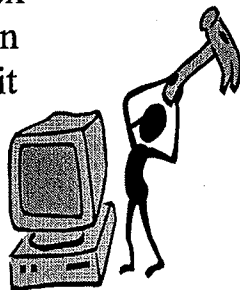
### Intra-personal Feelings/Perceptions

- Anxiety, fear
- Shame, guilt
- Frustration, anger
- Depression, psychosis
- Low energy and motivation
- Lack of self-efficacy
- Lack of meaning, identity, belonging
- Hopelessness

8

“For every complex problem there is an easy answer, and it is wrong.”

H.L. Mencken



9

## Effective Approaches to Motivate Change

*Stages of Change*

*Motivational Interviewing*

*Harm Reduction*

10

## Stages of Change

Precontemplation

Contemplation

Preparation

Action

Maintenance

(Relapse)



(Prochaska, Norcross and DiClemente's *Changing for Good*, 1994)

11



## Precontemplation

“Who, me?” Unaware or barely aware of a problem

No intention of changing behavior in foreseeable future

12



## Contemplation

Aware of problem, but not ready to change

Dealing with ambivalence, weighing pros and cons

13



## Preparation

Turns ambivalence into intention to take action

Sets reachable goals and makes specific plans

14

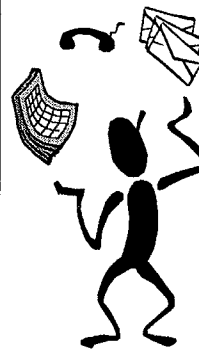


## Action

Commitment is clear

Modifies behavior, experiences, and environment to address problem

15



## Maintenance

Stabilizes behavioral changes/engages in new behaviors

Chooses effective support system

16



## (Relapse)

Viewed as a temporary loss of motivation

Relapse happens! A learning opportunity

17

## Stages of Change: Practical Implications

- Tailor your approach to the stage  
*"No matter how hard you try, you can't baptize a cat!"*
- Move one stage at a time
- Be patient, allow time

18

## What is Motivational Interviewing?



“They say you can lead a horse to water, but you can’t make him drink. But I say, you can salt the oats.”

-- Madeline Hunter

19

“A client-centered, directive intervention focused on resolving ambivalence in the direction of change”

“... not a series of techniques ... but a way of being with clients”

(Information on MI adapted from *Motivational Interviewing*. Miller and Rollnick, 1991)

## Motivational Interviewing

- Based on Stages of Change
- Assumes motivation is fluid and can be influenced
- Motivation influenced in the context of a relationship
- Principle tasks - to work with ambivalence and resistance
- Goal - to influence change *in the direction of* health

21

## Motivational Tasks Based on Stages of Change

### Precontemplation

- Raise doubt
- Increase perception of risks and problems

### Contemplation

- Explore ambivalence
- Don’t take sides

22

## Motivational Tasks Based on Stages of Change

### Preparation

- Create realistic plan
- Explore “what if this doesn’t work?”

### Action

- Encourage right-sized steps
- Explore “how is this working?”

23

## Motivational Tasks Based on Stages of Change

### Maintenance

- Create relapse prevention plan
- Explore new behaviors

### (Relapse)

- “What didn’t work?”
- “What can we learn from this?”

24



**GRACE:**  
**Five Principles of  
Motivational Interviewing**

- Generate a Gap
- Roll with Resistance
- Avoid Argumentation
- Can Do
- Express Empathy

25

*Principles of Motivational Interviewing:*

**Generate a Gap**



- Develop a discrepancy between individual's current behaviors *and* his/her stated values and interests
- Let client present arguments for change
- Acknowledge both the positives *and* negatives of behavioral change

26

*Principles of Motivational Interviewing:*

**Roll With Resistance**

- Seek to clarify, understand
- Invite consideration of new perspectives
- Reinforce person's role as a problem-solver



27

*Principles of Motivational Interviewing:*

**Avoid Argumentation**



- Keep on your client's side
- Arguing for change often promotes resistance, thus causing the client to defend the behavior you want them to change

28

*Principles of Motivational Interviewing:*

**Can Do**

- Increase individual's perception of self as a capable person
- Affirm positive statements and behaviors
- Offer options, instill hope
- Encourage consideration of role models, past successes



29

*Principles of Motivational Interviewing:*

**Express Empathy**



- Create a "free and friendly space" to explore difficult issues
- Use reflective listening
- An accepting attitude facilitates change, pressure to change thwarts it (paradox)

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## OARS: The Basic Skills of Motivational Interviewing



- Open-ended Questions
- Affirmations
- Reflective Listening
- Summaries

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## Open-ended Questions

- “How can I help you?”
- “Would you tell me about \_\_\_?”
- “How would you like things to be different?”
- “What are the positive things and what are the less good things about \_\_\_?”
- “What will you lose if you give up \_\_\_?”
  - “What have you tried before?”
  - “What do you want to do next?”

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## Affirmations

- Statements of recognition of client strengths
- Build confidence in ability to change
  - Must be congruent and genuine

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## Reflective Listening



“*Reflective listening* is the key to this work. The best motivational advice we can give you is to listen carefully to your clients. They will tell you what has worked and what hasn't. What moved them forward and shifted them backward. Whenever you are in doubt about what to do, listen.”

(Miller & Rollnick, 1991)

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## Levels of Reflection

### *1. Simple*

Repeating, rephrasing; staying close to the content

### *2. Amplified*

Paraphrasing, double-sided reflection; testing the meaning/what's going on below the surface

### *3. Feelings*

Emphasizing the emotional aspect of communication; deepest form

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## Summarizing

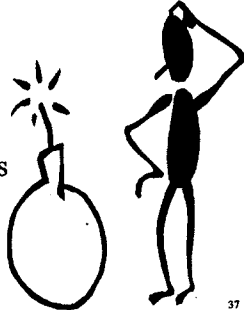
“*Let me see if I understand thus far ...*”

- Special form of reflective listening
  - Ensures clear communication
- Use at transitions in conversation
  - Be concise
  - Reflect ambivalence
- Accentuate “change talk”

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## What is Harm Reduction?

- A philosophy of care \*
- A set of public health interventions
- A grassroots advocacy effort



\* Primary focus of this presentation

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## Harm Reduction

“ ... a client-centered approach to working with people ‘where they are’ rather than ‘where they should be’ as dictated by treatment providers.”

- G. Alan Marlatt, Ph.D.

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## Harm Reduction

... an approach that establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free behavior ...

(Adapted from The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area between Intolerance and Neglect. Dr. Diane Riley, Canadian Centre on Substance Abuse)

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*“Habit is habit, and not to be flung out the window by any man, but coaxed downstairs a step at a time.”*

Mark Twain

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## Aim of Harm Reduction

To help individuals become more conscious of the risks of their behavior

and

to provide them with the tools and resources with which they can reduce harm to themselves and others


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## Harm Reduction Principles

- Humanistic, individualized approach
- Deals with whole person with complex needs
- Accepts risk as natural part of living
- Places risky behavior on a continuum
- Looks at person’s relationship to behavior as defined by him/herself

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## Harm Reduction Principles

- Change is often incremental 
- Any positive change seen as significant
- Interventions innovative, not rigid
- Involves communities most affected in organizing interventions/programs
- Applicable to both individual and systems change

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## Harm Reduction Applications for People Experiencing Homelessness

- Reaching out, engaging
  - Educating, advising
- Survival needs (food, shelter, clothing)
- Supplies (hygiene, condoms)
- Assessment and triage
  - Crisis intervention


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## Harm Reduction Applications ...

- Counseling, advising
  - Referral
  - Advocating
  - IM medications
- Nicotine gum/patches
- Decreasing frequency, amount of substance use
- Altering timing of substance use
- Bleach kits
- Needle and syringe exchange
- Methadone programs

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## “Harm Reduction” Applications to Promote Policy and Systems Change

- Develop relationships with neighbors, other agencies, public safety, shopkeepers
- Provide education and training in community
- Serve on committees, coalitions
- Write letters, editorials 
- Speak out at public hearings
- Educate public officials and policy-makers

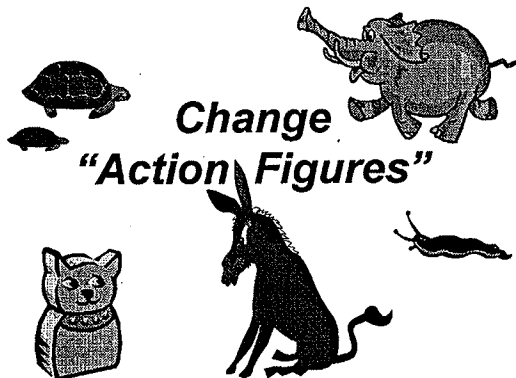
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## Suggested Reading

- *Changing for Good* by J.Prochaska, Norcross & DiClemente, 1994
- *Motivational Interviewing* by W.R.Miller & Rollnick, 1991
- *Practicing Harm Reduction Psychotherapy* by Patt Denning, 2000
- *Hooked* by Lonny Shavelson, 2001
- <http://www.motivationalinterview.org>

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## Change “Action Figures”



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## ACTIVITY 2 Stages of Change

*Note: Activity 1 provides an overview of all three change concepts. Activities 2, 3 and 4 focus on each change concept in greater detail.*

Purpose: To explore the process by which people make change decisions in their lives

Time: 20-25 minutes

Materials:

Handout: Stages of Change

Resource Paper: Stages of Change: Precontemplation, Contemplation, Preparation, Action, Maintenance

Preparation: Review the resource paper and the handout. The resource paper provides a more detailed description of the stages of change than the handout. If desired, the resource paper could also be used as a handout.

For additional reading, refer to the book Changing for Good by Prochaska, Norcross and DiClemente, 1994, or look up web-based resources on this topic.

Procedure:

1. Summarize and briefly discuss with the group the five stages: pre-contemplation, contemplation, preparation, action and maintenance. Also comment on the concept of relapse. Include the following key points:
  - Behavioral change may involve starting, ending, increasing, decreasing or altering a particular behavior. Behavior is defined broadly, not only referring to physical behaviors, but also to thoughts, attitudes and beliefs.
  - The change process is not necessarily linear. It's often more like a spiral than a straight line. Sometimes it is "two steps forward, one step backward."
  - The stages are not totally distinct from one another. They operate more like run-on sentences that merge and tangle with one another.
  - Stages cannot be skipped in general. One must move through each one eventually.
  - People move through the stages at their own pace and timing. For example, some linger for years in one or more of the pre-contemplative, contemplative or preparation stages. Others move quickly through them into the action phase.
  - Each stage (and relapse) requires a different stance and response by the care provider.
2. Next, give an example of a simplified change process in which one advances through the various stages in a brief and linear manner, for the purpose of illustration. Use the following example or make up your own.

**Pre-contemplative:** All of your clothes are dirty and in need of laundering, but you ignore this and basically choose not to think about it.

**Contemplative:** You run out of clean clothes and come to the realization that you probably ought to clean them, especially since someone made a comment about it today. Still, you have a tempting thought that surely you could get by a few more days!

**Preparation:** You make a mental note that you have to buy more laundry detergent at the store. You sort your clothes into piles and decide you'll do one pile each evening until you've completed the job.

**Action:** You wash your clothes over the course of several days.

**Maintenance:** You decide that rather than letting your laundry pile up until you have nothing to wear, you'll do one load of laundry each week to make the task more manageable.

3. Now ask participants to come up with their own examples either true to life or imagined. Have participants share their examples with someone else or the whole group. This exercise helps give a clearer sense of what each of the stages entails.

4. As a final step, present a case of an outreach client with whom you have worked over time (or have a group member provide a case example). Choose a particular issue illustrating the client's movement through the five stages of change from pre-contemplation to maintenance. For example, persuading the client to receive medical or mental health care, to apply for financial entitlements, to seek treatment for chemical dependency, or to access housing. Discuss the various barriers that had to be overcome. Also, note the movement back and forth between the various stages that occurred.

# Stages of Change: Precontemplation

David B. Rosengren, Ph.D. & Carl Rimmele, Ph.D.

## Definition

People in precontemplation stage have no intention of changing their behavior for the foreseeable future. They are not thinking about changing their behavior, and may not see the behavior as a problem when asked. They certainly do not believe it is as problematic as external observers see it. These individuals are often labeled as "resistant" or in "denial."

## Things to Consider

Reasons for precontemplation can fit into the "four R's": reluctance, rebellion, resignation, and rationalization. DiClemente (1991) described why these groups do not consider change and methods for intervening.

- *Reluctant* precontemplator. Inertia or lack of information prevents the person from being fully aware of a problem. Sensitive delivered test information can be very helpful for this person.
- *Rebellious* precontemplator. A heavy investment in the problem behavior or in controlling a situation makes the person actively resistant and often hostile. Providing choices with this group seems to be helpful.
- *Resigned* precontemplator. A belief in the inability to change the behavior keeps the person stuck, and there is a lack of energy for and investment in change as a result. The job here is to instill hope and explore barriers to change.
- *Rationalizing* contemplator. The client determines there is no problem, the odds of personal risk are in his or her favor, or the problem is really someone else's. The difference from rebellion is the process is more thinking than feeling for a "rationalizer". Empathy and reflective listening are suggested tools with a particular emphasis on double-sided reflections.

## Therapist Tasks

- Identify "the problem" - this often means something different for the therapist and the client.
- Be aware of difference between reason and rationalization. A person, well aware of the risks and problems, may choose to continue the behavior. We may not change them in the face of this informed choice. Our work may have an impact later.
- Recognize that more is not always better. More intensity will produce fewer results with this group. Use MI strategies to raise awareness and doubt. Increase the client's perceptions of risks and problems with current behavior.
- Remember the goal is not to make precontemplators change immediately, but to help move them to contemplation.

## Strategies

Primary tools are providing information and raising doubt. However, basic skills such as reflective listening, open-ended questions, and functioning as a collaborator (rather than an educator) may be enough. Matching interventions to the type of precontemplators is also helpful.

## Outcome

The client begins to consider that a problem or matter of concern exists.

Adapted from DiClemente, 1991

# Stages of Change: Contemplation

David B. Rosengren, Ph.D. & Carl Rimmele, Ph.D.

## Definition

The person is aware a problem exists and seriously considers, action, but has not yet made a commitment to an action.

## Things to Consider

This is a paradoxical stage of change. The client is willing to consider the problem and possibility of change, yet ambivalence can make contemplation a chronic condition. Clients are quite open to information and yet wait for the one final piece of information that will compel them to change. It's almost as they either wait for a magic moment or an irresistible piece of information that will make the decision for them.

This is a particularly opportune time for motivational interviewing strategies. Contemplation and interest in change are not commitment. Information and incentives to change are important elements for assisting contemplators. Personally relevant information can have a strong impact at this stage.

## Therapist Tasks

- Consider the pros and cons (from the clients perspective) of the problem behavior, as well as the pros and cons of change.
- Gather information about past change attempts. Frame these in terms of "some success" rather than change failures."
- Explore options the client has considered for the change process and offer additional options where indicated and if the client is interested. Remember that our clients are rarely novices to the change process.
- Elicit change statements.

## Strategies

Inquire about the "good and less good" things of the problem behavior; explore concerns.

## Outcome

The client is making change statements and makes a tentative commitment to changing the behavior.

Adapted from DiClemente, 1991



# Stages of Change: Preparation

David B. Rosengren, Ph.D. and Carl Rimmele, Ph.D.

## Definition

The person is intent upon taking action soon and often report some steps in that direction. Thus, this stage is a combination of behavioral actions and intentions. This is a relatively transitory stage that is characterized by the individual's making a firm commitment to the change process. There may already be some initial steps taken towards change, but even if not, most clients will make a serious attempt at change soon (i.e. one month).

## Things to Consider

Despite making a decision to alter behavior, change is not automatic. Ambivalence, though diminishing, is still present. The decision-making process is still occurring and pros and cons are still being weighed.

## Therapist Tasks

- Assess strength of commitment. Strong verbal statements may be a sign of weak commitment. A realistic evaluation of problem area and a calm dedication to making this a top priority are good indicators
- Examine barriers and elicit solutions (what will the first week be like?)
- Build coping behaviors
- Reinforce commitment but provide words of caution where enthusiasm may outdistance actual skills

## Strategies

Ask a key question. Assist client in building an action plan and removing barriers. Some examples of key questions are:

- What do you think you will do?
- What's the next step?
- It sounds like things can't stay how they are now. What are you going to do?

One structure for a change includes six elements:

- Specific statement of changes to be made
- Why these changes are important
- Steps in making these changes
- Inclusion of others in the plan
- A method for evaluating the plan
- Identification of possible barriers to the plan

## Outcome

The client is making clear change statements and has an action plan in place.

# **Stages of Change: Action**

David B. Rosengren, Ph.D. & Carl Rimmele, Ph.D.

## **Definition**

The person is aware a problem exists and actively modifies their behavior, experiences and environment in order to overcome the problem. Commitment is clear and a great deal of effort is expended towards making changes.

## **Things to Consider**

Action involves a sustained effort at making changes. This period usually lasts from one to six months. Clients have made a plan and have begun implementing it. Ambivalence and commitment are still issues.

Too often people do not go back and re-evaluate their change plan. Where is it working? Where did it not? Is there a procedure for re-evaluating the plan? Has there been any planning for handling little slips?

Recognize differing levels of readiness to change among issues and the recycling process in the Stages of Change

## **Therapist Tasks**

Help increase client's self-efficacy by:

- Focusing on successful activity
- Reaffirming commitment
- Making intrinsic attributions for success

Offer successful models with a variety of action options.

The therapist may be used more as a monitor than a change agent.

## **Strategies**

This stage is familiar to most therapists and involves interventions they have experience in providing (e.g. skill building, group work, relapse prevention, active problem solving, counter-conditioning, stimulus control, contingency management).

## **Outcome**

Clear changes in behavior are manifested and the risk of relapse diminishes as new behavior patterns replace the old problematic behavior.

Adapted from DiClemente, 1991; Prochaska and Norcross, 1994

# **Stages of Change: Maintenance**

David B. Rosengren, Ph.D. & Carl Rimmele, Ph.D.

## **Definition**

The person has made a sustained change wherein a new pattern of behavior has replaced the old. Behavior is firmly established and threat of relapse becomes less intense.

## **Things to consider**

Maintenance is often viewed as an afterthought where very little activity occurs. However, maintenance is not a static stage. Relapse is possible and occurs for a variety of reasons. Most relapses are not automatic but occur after an initial slip has occurred. Client's will often turn to a therapist during what Saul Shiffman calls a relapse crisis (i.e., they've slipped or are about to). During these times the client's self-efficacy is weakened and fear is high. Clients seek reassurance from therapists while trying to make sense of the crisis. Review of the spiral model of the Stages of Change can be very helpful for clients at these times.

## **Therapist Tasks**

Therapists do not usually see clients that are well-established in maintenance. If they do, a review of the action plan and a strategy for periodic review of the plan are useful. More often therapists will see clients when a relapse crisis is present. Tasks for these times are:

- Exploration of the factors precipitating and maintaining the crisis
- Provision of information
- Feedback about plans
- Empathy

## **Strategies**

When crises are occurring, slow the process down. Explore what succeeded, as well as what is precipitating their current concerns or crisis. Offer models of success while normalizing relapse in situations where change is not easily accomplished. If the client is returning to discuss their success, reinforce their active efforts in making change possible and their commitment to change.

## **Outcome**

Client exits the Stage of Change spiral. For a relapsing client, they re-enter the contemplation or preparation stage.

Adapted from DiClemente, 1991; Prochaska and Norcross, 1994

# Stages of Change

## **Precontemplation**

Person has no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or barely aware of their problems. Others might wish to change, but this is quite different from seriously considering changing within the next six months.

## **Contemplation**

Person is aware that a problem exists and is seriously thinking about addressing it, but is not yet committed to preparing for and taking action. The individual is experiencing ambivalence in this stage, weighing the pros and cons. One can remain stuck in this phase for a long period of time.

## **Preparation**

Person is committed to taking action soon and is making concrete steps to do so. Individuals in this stage often report small behavioral changes in a positive direction. Ambivalence may still be present but is diminishing.

## **Action**

Person actively modifies his/her behavior, experiences, or environment to overcome the problem. One's commitment is clear. Considerable commitment of time and energy is required in this stage. Action is a critical part of changing, but is not to be confused with change itself which is a process encompassing all of the stages of change

## **Maintenance**

Person continues to work at stabilizing behavioral change and consolidating the gains made during the action phase. Effort is put forth to prevent relapse. The maintenance stage is not static, but very active. It often requires a great deal of hard work and perseverance. It is also a time to enjoy the rewards resulting from the change.

## **(Relapse)**

Person reverts to the problem behavior. This might happen at any time during the change process. The duration of relapse may be very brief or lengthy. Relapse is not a stage of change but is seen as a normal occurrence in the change process for many people. It is viewed as a temporary loss of motivation and a learning opportunity.

## ACTIVITY 3 Motivational Interviewing

*Note: Activity 1 provides an overview of all three change concepts. Activities 2, 3 and 4 focus on each change concept in greater detail.*

Purpose: To become familiar with the basic tenets of motivational interviewing and its usefulness in outreach

Time: 30-40 minutes

Materials:

Handout: What is Motivational Interviewing?

Handout: Motivational Responses Based on Stages of Change

Handout: GRACE: Five Principles of Motivational Interviewing

Handout: OARS: The Basic Skills of Motivational Interviewing

Handout: Reflective Listening

Handout: Summaries

Preparation: Review the various handouts above related to motivational interviewing. Prepare a presentation that provides a basic primer on this topic using the handouts as a guide.

For additional reading, refer to the book Motivational Interviewing by Miller and Rollnick, 1991 or 2<sup>nd</sup> edition 2002. There are various useful web-based resources on this topic as well.

Procedure:

1. Distribute the six handouts to participants.
2. Give a didactic presentation on motivational interviewing using the handouts as supporting material. Allow ample time for questions and clarification.
3. Continue the activity by taking time to practice in particular the skills of reflective listening and summarizing. For guidance, refer to Activities 4 and 6 in Module III, Section C on "Listening with all Six Senses." If the group practiced these skills previously in the training, consider moving on to the next step.
4. Break into groups of three for a role-play exercise in which there is a designated outreach worker, a homeless client, and an observer in each group.
  - The **client** assumes the role of a homeless person living on the streets. He or she assumes a certain persona with various concerns or problems common to those experienced by homeless people. For example, the person might have a heroin addiction, an abscess that is getting worse, is feeling hopeless, or needs medical and addictions treatment but doesn't trust "professionals."
  - The **outreach worker** has had some contact with the individual in the past and has established some rapport and trust. On this contact there seems to

be an opening to talk in greater detail about the homeless individual's situation.

- The **observer** listens in on the interchange between the worker and client without making any comments or directly participating in any way.

5. Instruct the outreach worker and client to enter into a "typical" conversation. The worker is to listen for what stage of readiness for change a client might be at given a particular problem that the client raises. The worker thus responds accordingly using the basic skills of motivational interviewing. The worker should try to use each basic skill (open-ended questions, affirmations, reflective listening, and summaries) as often as possible during the interaction.

6. During the role-play the observer is to note, preferably in writing, in what manner and how frequently the outreach worker uses each of the four skills.

7. At the completion of the role-play, the interviewer and client discuss what the experience was like from each person's perspective. The observer reports on the results of her or his observations of the worker and adds other comments or insights as appropriate.

8. If time permits, conduct three different role-plays in which each participant is given an opportunity to play all three roles.

# What is Motivational Interviewing?

David B. Rosengren, Ph.D.

1. Motivational Interviewing (MI) is a client-centered, directive approach focused on resolving ambivalence in the direction of change.
2. The approach relies heavily on the client-centered counseling skills espoused by Carl Rogers, but differs in that the skills are used in a highly directive manner. In this sense, workers are actively moving clients toward self-examination and increased awareness of the problem area.
3. Confrontation is a goal of MI, but it is not a style. MI believes that client resistance can be influenced, up or down, by the worker. The goal is to have clients examine problem areas in their life without feeling the need to defend their behavior. There has been compelling research which suggests that high levels of worker confrontation leads to greater resistance which in turn leads to an increase in the problem behavior by the client.
4. Although the goal is to create a safe atmosphere, it is not necessarily to make the client comfortable with the problem behavior. Instead, the goal is to make clients aware of the behavior and how this may be at odds with their desired goals. The motivation for change comes from within the client and is a function of this discrepancy. Thus, clients may feel uncomfortable, but it's the behavior, not the worker, creating the discomfort.
5. The client, not the worker, ascribes meaning to a behavior. Problem behaviors are stated in a factual way and are not ammunition in support of an argument. They are information for the client to weigh and decide what they mean.
6. The worker is active and does state opinions. However, it is recognized that in the end the client, not the worker, will decide (even in the face of court-mandates) what he or she will do about a behavior and will be responsible for enacting any change that occurs. Feedback and advice are offered, but in the context of acknowledging the client's right to choose and the many paths to a solution.
7. MI believes that the resources for change are often within the client. Thus, clients do not necessarily have to be trained to do new skills. Instead, they need to be freed from the ambivalence and other obstacles that prevent them from using their skills.
8. MI is not unique. It has borrowed heavily from many other writers. What is unique is how the elements are combined and the timing of interventions. Timing is important within Mi. Intervening in particular ways at certain moments is important.
9. MI believes labels are unnecessary for the change process.
10. MI uses the Stages of Change to understand the process of change and the role of ambivalence within that process.
11. If no change occurs, but you end the intervention on good terms, the door is left open for possible future change.

(Adapted from Miller & Rollnick, Motivational Interviewing, 1991)

# MOTIVATIONAL RESPONSES BASED ON STAGES OF CHANGE

CLIENT STAGE	MOTIVATIONAL RESPONSE
Precontemplation	Raise doubt, increase perception of risks and problems. Not a good time for prescriptive advice.
Contemplation	Evoke <i>client's</i> reasons for change, strengthen self-efficacy, hope, and confidence.
Commitment	Set acceptable goals and develop achievable and effective strategies.
Action	Facilitate necessary skills and resources for immediate change.
Maintenance	Facilitate supports for long-term change, develop relapse prevention and control supports.
(Relapse)	Renew process quickly.



# **GRACE:**

## **Five Principles of Motivational Interviewing**

David B. Rosengren, Ph.D.

### **Generate a Gap**

- A gap is a motivating discrepancy. It is the difference between where I see myself now and where I want to be.
- Discrepancy does not come from outside the client but from within. Thus, the worker's job is not to create the discrepancy but simply to help the client see that the behaviors in question are discrepant from the things held most dear.
- Thus, useful Motivational Interviewing (MI) topics are: (a) what are the client's most important values or goals (where I want to be) and (b) his or her present condition with regard to the target behavior (where I am)
- Clients should present the arguments for change. This is consistent with Bem's Self-Perception Theory, which in essence states that we come to know what we believe by hearing ourselves talk.
- MI strategies are designed to elicit and reinforce change statements. These statements include recognition of the problem, expression of concern, intention to change, and optimism for this change.

### **Roll with Resistance**

- Resistance is energy. Use it to help the client move forward.
- Opposing resistance generally strengthens it, so don't push.
- If resistance increases, you need to change what you are doing.
- Offer new perceptions but don't impose or argue them.
- You do not have to answer a client's objection or resistance. Turn them back to the client, and use him or her as a resource for finding solutions.

### **Avoid Arguing**

- The more a client resists, the less likely change is to occur (Miller, Benefield & Tonigan, 1993). Therefore, the key to effective MI is to keep client resistance low.
- Client resistance behavior is heavily influenced by the worker's behavior.
- The more workers use overt confrontation, the more clients drink (Bien, Miller, & Tonigan, 1993). Examples of overt confrontation include arguing, challenging, sarcasm, incredulity, head-to-head disputes, and restating negative information about the client.
- Avoid arguing for change. It means the client is arguing against it. Change strategies quickly.
- Clients do not have to accept a label or diagnosis to change. This removes a frequent source of argumentation.

## **Can Do**

- The client must believe she or he can successfully perform a specific act. It is related to, but not the same as, self-esteem. Individuals with low esteem can view themselves as capable in specific spheres. Building a "can do" attitude can enhance self-esteem.
- Without this "can do" attitude, perceived risk turns to defensiveness rather than leading to behavior change.
- Impart belief in the possibility of change. The truth is helpful here – there are many different pathways to change. Most people who decide to make a change in a problem behavior eventually succeed.
- Remember, it is always the client's choice whether and how to change. You can not make these decisions for the client.

## **Express Empathy**

- The general goal is to create an atmosphere in which the client safely explores conflicts and faces difficult realities.
- We create this atmosphere by using reflective listening. A high level of skill in reflective listening allows us to produce the conditions Rogers believes necessary for counseling: non-possessive warmth, accurate understanding, and unconditional positive regard.
- This position is opposite of the principle that if you can make the person feel bad enough, he or she will change. The paradox is that acceptance facilitates change, pressure to change blocks it.
- Empathy does not mean identification with the client. "Having been there" is neither a necessary nor a sufficient condition for effective intervention. In fact, over-identification can interfere with effective counseling.

(Adapted from Miller & Rollnick, Motivational Interviewing 1991)

# O.A.R.S.

## The Basic Skills of Motivational Interviewing

David B. Rosengren, Ph.D.

1. Miller and Rollnick (1991) characterize Motivational Interviewing (MI) as *not a series of techniques* but instead *a way of being with clients*. As such, it is not so much what you do, but how you do it that is important. MI is not a prescriptive approach to working with people. There is no one way that represents MI. However, certain basic skills (micro-skills) are necessary prerequisites for this way of being.
2. O.A.R.S. are the basic skills of MI. They are used throughout an interaction. As such, the worker must have a good working knowledge of these skills to be successful in using MI. However, simply doing these techniques does not represent MI. It is the combination of these skills, in concert with specific timing and elements, that distinguishes the character of MI from other interventions.
3. The acronym O.A.R.S. reflects the following elements
  - Open-ended Questions
  - Affirmations
  - Reflective Listening
  - Summaries
4. Whenever you are "stuck" in an interaction you can fall back on these skills to help yourself and the client move. O.A.R.S. are an integral part of helping clients move ahead in the direction of positive change.

Adapted from Miller & Rollnick, 1993 and David Rosengren.

# Reflective Listening

"Listening looks easy, but it's not simple. Every head is a world."  
Cuban proverb

Reflective listening is a primary skill in outreach. It is the pathway for engaging others in relationship, building trust, and fostering motivation to change. Reflective listening appears deceptively easy, but it takes hard work and skill to do well.

Sometimes the "skills" we use in working with clients do not exemplify reflective listening but instead serve as roadblocks to effective communication. Examples include misinterpreting what is said or assuming what a person needs.

It is vital to learn to *think* reflectively. This is a way of thinking that accompanies good reflective listening that includes interest in what the person has to say and respect for the person's inner wisdom. Its key element is a hypothesis testing approach to listening. What you think the person means may not be what they really mean. Listening breakdowns occur in any of three places:

- Speaker does not say what is meant
- Listener does not hear correctly
- Listener gives a different interpretation to what the words mean

Reflective listening is meant to close the loop in communication to ensure breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This may feel presumptuous, yet it leads to clarification and greater exploration, whereas questions tend to interrupt the client's flow. Some people find it helpful to use some standard phrases:

- "So you feel..."
- "It sounds like you..."
- "You're wondering if..."

There are three basic levels of reflective listening that may deepen or increase the intimacy and thereby change the affective tone of an interaction. In general, the depth should match the situation. Examples of the three levels include:

1. Repeating or rephrasing – listener repeats or substitutes synonyms or phrases; stays close to what the speaker has said
2. Paraphrasing – listener makes a major restatement in which the speaker's meaning is inferred
3. Reflection of feeling – listener emphasizes emotional aspects of communication through feeling statements – deepest form of listening

Varying the levels of reflection is effective in listening. Also, at times there are benefits to over-stating or under-stating a reflection. An overstatement (i.e. an amplified reflection) may cause a person to back away from a position while an understatement may lead to the feeling intensity continuing and deepening.

(Adapted from Motivational Interviewing materials by David B. Rosengren, Ph.D. and from Motivational Interviewing by Miller & Rollnick, 1991)

# Summaries

Summaries are special applications of reflective listening. They can be used throughout a conversation but are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end.

Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change.

## Structure of Summaries

- 1) Begin with a statement indicating you are making a summary. For example:
  - Let me see if I understand so far ...
  - Here is what I've heard. Tell me if I've missed anything.
  
- 2) Give special attention to Change Statements. These are statements made by the client that point towards a willingness to change. Miller and Rollnick have identified four types of change statements, all of which overlap significantly:
  - Problem recognition *"My use has gotten a little out of hand at times."*
  - Concern *"If I don't stop, something bad is going to happen."*
  - Intent to change *"I'm going to do something, I'm just not sure what it is yet."*
  - Optimism *"I know I can get a handle on this problem."*
  
- 3) If the person expresses ambivalence, it is useful to include both sides in the summary statement. For example: "On the one hand ..., on the other hand ..."
  
- 4) It is legitimate to include information in summary statements from other sources (e.g. your own clinical knowledge, research, courts, family).
  
- 5) Be concise.
  
- 6) End with an invitation. For example:
  - Did I miss anything?
  - If that's accurate, what other points are there to consider?
  - Anything you want to add or correct?
  
- 7) Depending on the response of the client to your summary statement, it may lead naturally to planning for or taking concrete steps towards the change goal.

(Adapted from Motivational Interviewing materials by David B. Rosengren, Ph.D. and from Motivational Interviewing by Miller & Rollnick, 1991)

## ACTIVITY 4 Harm Reduction

“... a client-centered approach to working with people  
'where they are' rather than 'where they should be'  
as dictated by treatment providers.”  
G. Alan Marlatt

*Note: Activity 1 provides an overview of all three change concepts. Activities 2, 3 and 4 focus on each change concept in greater detail.*

Purpose: To develop a basic understanding of the concept of harm reduction and its applicability to change in the outreach context

Time: 20 minutes

Materials:

Handout: Principles of Harm Reduction

Preparation:

The concept of harm reduction is variously referred to as 1) a philosophy of care, 2) a set of public health interventions, and 3) a grassroots advocacy effort. The primary focus for this activity is on harm reduction as a philosophy of care based on the principles noted on the handout.

Harm reduction as a philosophy of care is a client-centered approach that acknowledges that behavioral change is often uneven and incremental. In this approach, the client determines the pace and steps toward change. The role of the worker is to help motivate the person in the direction of change using the stages of change concept to identify the client's readiness for change. Any step in a positive direction towards change is considered significant in the harm reduction philosophy.

The notion of reducing harm or risk is not a new idea. Human beings have practiced it since the beginning of time. Virtually all of our routine activities of moderation, self-care, and self-protection are intended to decrease risk or harm. It seems that the controversy that surrounds harm reduction is related to its application to certain controversial behaviors than to the concept of harm reduction itself.

Review the handout and prepare a brief presentation on the concept of harm reduction with an emphasis on the definition, goals, and principles of harm reduction as a philosophy of care.

Suggested background reading:

- Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviors by G. Alan Marlatt. Guilford Press, 1998.

- Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions by Patt Denning, Guilford Press, 2000.
- "Harm Reduction: Concepts and Practice" [www.ccsa.ca/docs/wgharm.htm](http://www.ccsa.ca/docs/wgharm.htm)

Procedure:

1. Begin by asking the group to name as many examples of harm reduction practices in everyday life that they can think of. Encourage them to think broadly in regard to personal behaviors as well as public health interventions. Some responses you might expect to hear:

E.g. seatbelts, bike helmets, brushing teeth, bathing, eating non-fatty foods, filtered cigarettes, nicotine gum/patches, drinking moderately, condoms, methadone, bleach kits, needle and syringe exchange, education, sewage systems, fluoride in drinking water, vaccinations, health screening, garbage pickup, alcohol server training, etc.

2. Distribute the handout. Give a brief presentation about harm reduction, drawing from the comments in the preparation section above, the handout, your own expertise and other reading. Provide examples from your own outreach experience in which you employed a harm reduction approach.

3. Facilitate a group discussion asking participants to share their own thoughts and questions about using a harm reduction approach in outreach. Encourage them to share examples from their own outreach experience. Acknowledge that this issue remains a controversial one for some providers. Explore these varying opinions within the group.

4. Close the activity by summarizing the connections between the concepts of stages of change, motivational interviewing, and harm reduction and their applicability to outreach to people experiencing homelessness.

# Principles of Harm Reduction

## Definition

Harm reduction is a set of strategies and tactics that encourage individuals to reduce the risk or harm to themselves and their communities by their various behaviors.

## Goal

The goal of harm reduction is to educate the person to become more conscious of the risks of their behavior and provide them with the tools and resources with which they can reduce their risk.

## Principles

- A humanistic, individualistic approach
- Does not deal solely with behaviors, but with whole person with complex needs
- Provides an alternative and challenge to traditional disease model and/or moral criminal models
- Accepts that risk is a natural part of our lives
- Places risky behavior on a continuum within context of person's life
- Looks at person's relationship to the behavior as defined by him/herself
- Accepts that behavioral change is often incremental
- Any positive change is seen as significant
- Interventions are not rigid, require creativity and innovation reflective of person's life situation
- Is helpful for communities most affected to be involved in creating safe places to get help by organizing harm reduction interventions and programs
- Though commonly associated with drug use, harm reduction is applicable to any social welfare and /or public health issue

Adapted from: "Recovery Readiness: Strategies That Bring Treatment to Addicts Where They Are" by Richard Elovich and Michael Cowing and National Harm Reduction Working Group Report from October 21-23, 1993 meeting.



# **Module 5: PARTNERSHIP**

## **EXPANDING THE CIRCLE OF CARE**

### **Purpose**

The purpose of Module 5 is to help outreach workers become more knowledgeable of the community in which they work, be aware of and make effective use of community resources, develop the skills needed to make successful referrals, and enhance their advocacy skills.

## **5A: Vision for a Healthy Community**

### **Purpose**

To increase awareness of what a healthy community would look like, especially from the perspective of people experiencing homelessness

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 What is a “Healthy Community?”**

Purpose: To help participants define what is a community, describe the various “communities within your community,” and identify the characteristics of a “healthy community”

Time: 20 minutes (approximately 5 minutes for each step)

Materials:

Resource paper: “Understanding and Describing the Community” from the Community Toolbox online at <http://ctb.lsi.ukans.edu/>

Flip chart and marker

Preparation: Read the resource paper “Understanding and Describing the Community” (read it online or print it out) and review the procedure steps below.

Procedure:

1. Ask participants to give their own definitions of what is a community. Summarize by observing that communities are most often defined by geography (e.g. neighborhood, city), common experiences among people (e.g. African American, Viet Nam vets), and by common interests (e.g. artists, activists).
2. Next, ask the group to identify various “communities within your community” that they can name. If group members are from the same geographic community, ask them to respond in reference to their own locale. List these communities on a flipchart (e.g. specific places of worship, businesses, clubs, schools, Latino, gay/lesbian, homeless, etc.).
3. As a third part of this activity, ask the group to describe what they consider the characteristics of a “healthy community.” For example, a community that provides needed services and amenities for all its members (including those living on the margins), is safe, has open spaces, good schools, affordable housing, accessible health care, is diverse, tolerant, inclusive in decision making, treats its members justly, and so forth. List these on a flipchart as well.
4. As a follow-up, ask the group to think about how a person experiencing homelessness and health/mental health/substance use issues might respond to this same question (step 3 above) regarding the characteristics of a “healthy community.” Are these responses any different from those of people who have homes, jobs, and enjoy relative stability in their lives? This discussion provides a natural lead into Activity II below.

## **ACTIVITY 2 The Community at Street Level (A “Public Hearing”)**

Purpose: To understand the community in which you live/work from the perspective of homeless individuals and families living on the streets

Time: 30-60 minutes, depending on the number of participants and amount of time allotted for the public hearing

Materials:

Resource paper: “Understanding and Describing the Community” from the Community Toolbox online at <http://ctb.lsi.ukans.edu/>

Preparation:

Read the resource paper “Understanding and Describing the Community” (see above)

Set up tables and chairs in the room for a “public hearing” to take place. (Refreshments would be a nice touch!)

If possible, invite some homeless or formerly homeless individuals to participate in this activity. It would be especially informative to tap the knowledge and wisdom of those who represent different sub-populations among people experiencing homelessness.

Procedure:

1. Divide into small groups of 2-5 participants. Each group is to take on the identity of a particular sub-group of homeless people in the community (e.g. youth, IV drug users, elderly single men, families, mentally ill, etc.). Each group can choose their identity based on personal interest.
2. Explain that the City Council, in an uncharacteristic move, has requested a special public hearing focused on homelessness. Only those people who are currently homeless, or have recently experienced homelessness, are being asked to provide testimony at this hearing. The main purpose of the hearing is to have community members listen and learn what it's like to experience homelessness in this particular city/town/neighborhood, what services are and are not available, and what can be done to better address people's needs.
3. The task of each “homeless sub-group” is to outline the main points they intend to make at this hearing and to illustrate these points with personal stories, examples, and anecdotes. The City Council is particularly interested in the following issues:
  - What is the level of physical safety for homeless people? To what degree do you experience violence directed towards you by non-homeless people in the community?

- How available and accessible are “survival services” (food, shelter, clothing, etc.)?
- How “user-friendly” are health, welfare, housing, and employment services?
- How do local policies and ordinances affect you (e.g. public encampment sweeps, anti-panhandling laws)?
- How do you rate the attitudes and practices of local police, emergency medical services, missions and shelters, religious institutions, businesspeople, etc. towards homeless people?
- Who do you consider your allies in the community? Your antagonists?
- Other?

Allow adequate time for the group to prepare their testimony.

4. Hold the public hearing and have each “homeless sub-group” give their testimony. A moderator will be needed to keep the meeting on task and within the time allotted. All members of the sub-group should have some role in providing the testimony. Everyone else is part of the audience. Allow time for a question and answer interchange between those making statements and the audience.

5. The moderator should conclude the hearing by providing a brief summary statement of what themes emerged out of the hearing and thanking everyone for their participation.

## **ACTIVITY 3 Writing a Community Description**

Purpose: To help outreach workers learn as much as they can about the communities in which they work

Time: 25 minutes

Materials: Handout: Writing a Community Description

Preparation:

Read "Understanding and Describing the Community" from the Community Toolbox online at <http://ctb.lsi.ukans.edu/>

Procedure:

1. Explain the benefits of writing a community description based on your reading of "Understanding and Describing the Community."
2. Divide into groups in which each group is made up of participants from the same community in which they are doing outreach. If everyone present is working in the same community, do this activity as one group. If individual participants are the only ones from a particular community, have them work on their own.
3. Distribute the handout, which is to be used as a worksheet, and review the questions on it.
4. Instruct participants to respond to the questions in writing as best as they can. Allow approximately ten minutes or so for this step.
5. Reconvene as a large group (if working in smaller groups) and review both what people already know about their communities, and what they might still need to learn. Inquire how they might go about gaining this information and knowledge.
6. Close the activity by encouraging participants to share and discuss this initial community description with others in their program and to follow up with filling in the gaps in their knowledge and understanding of the community.

## **Writing a Community Description**

Name of the community in which you do outreach?

Geographic boundaries of the community you serve?

General history of the community?

Demographics: racial/ethnic makeup, male/female ratio, sexual minority ratio, age, economic standing, education levels?

Significant changes that are currently taking place, or are being planned?

Issues of greatest concern to the community?

What is general attitude towards people experiencing homelessness?

General attitude towards organizations/agencies serving homeless people?

Morale and level of involvement of community members?

Key allies to get things done to address problem of homelessness (individuals, associations, businesses, faith organizations, coalitions, agencies, politicians)?

Key antagonists to addressing homelessness concerns?

## **5B: Community Resources and Services**

### **Purpose**

To ensure outreach workers are knowledgeable of resources and services in the community and how to make use of them effectively

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.



## **ACTIVITY 1 Working Effectively in the Community**

Purpose: To help participants develop ideas about ways to work effectively with the community in which they are doing outreach

Time: 20 minutes

Materials: Handout: Working Effectively in the Community

### Preparation:

It takes a community to do effective outreach! Outreach at its best is not just the work of a few individual outreach workers, but requires the support of a committed and involved community, such as concerned citizens, police, bus drivers, businesses, social service organizations, civic groups, faith-based groups, politicians, and others.

Outreach workers play a vital role in eliciting and galvanizing this support from other community members and organizations. Without this support, outreach efforts are made doubly hard. When we think of community resources, we must think not only of services, but also of people and community groups as resources.

Resistance from some segments of the community will invariably exist. This resistance often stems from lack of awareness and misinformation about homelessness, negative attitudes towards homeless people, narrow self-interest, and certain beliefs.

Outreach workers, by reaching out to these non-homeless members of the community, whatever their level of openness or resistance, can help to enhance their outreach efforts by listening, engaging, educating, and ultimately advocating with them on behalf of those members of the community who are experiencing homelessness. In the long run, this stance will likely produce more favorable results than pursuing an adversarial approach.

Review the handout and think of ideas and examples from your own experience about ways to work more effectively within the community. Acquaint yourself with the activity steps below and tailor as you see fit.

### Procedure:

1. Before distributing the handout, read or summarize the introductory comments to this activity. Invite a brief discussion about the idea of "reaching out" to the community itself.
2. Next, ask the group to identify the various ways they are involved in "reaching out" to community in their current work. Have them give specific examples.

3. Then invite the group brainstorm new ways they might reach out within the community or to enhance the involvements they already are undertaking. Refer to the handout at this point for the purpose of sparking ideas.

4. Encourage participants, individually or collectively, to take at least one idea from this brainstorm and pursue what steps would be required to put it into practice. (If possible, follow up on this at a future time to see what progress has been made.)

## **Working Effectively in the Community**

- Through your attitude, actions and words, be an “ambassador” for homeless people in your encounters with others in the community.
- Promote a spirit of collaboration with shopkeepers, police, clergy, and “natural helpers” in the neighborhood. They are valuable “eyes and ears” to assist you in your outreach efforts.
- Develop and maintain a strong working relationship with at least one staff person from key social service organizations.
- Offer to provide education and training for other organizations about homelessness issues. Likewise, invite them to provide relevant training for your team/ organization.
- Consider setting up an inter-agency consortium to meet training needs. Each participating agency hosts and provides a workshop on a rotating basis. Topics are chosen by a representative planning group.
- Go out on outreach “rounds” at selected agencies on a scheduled basis. This provides an opportunity to maintain regular contact with agency personnel, to accept referrals, make follow-up contacts, and provide consultation.
- Participate in developing formal interagency agreements to address issues specific to the care of homeless people. For example, ways to expedite referrals, homeless-specific admission criteria and discharge planning, sharing of information, etc.
- Provide advocacy on behalf of other community programs that are part of the larger network of services for homeless people.
- Invite others to open houses, celebrations, farewells, fundraisers, and other special occasions. Attend other agencies’ functions.
- Make a special effort to reach out to organizations “on the fringes” of the human services community.

## **ACTIVITY 2 Short-list of Community Resources for Homeless People**

Purpose: To provide outreach workers with a useful short-list of relevant community resources for various populations and needs

Time: 15 minutes

Materials: Handout: Community Resources

Preparation: Familiarize yourself with the Community Resources grid. You may want to complete it on your own based on resources in your own community.

Procedure:

1. Distribute the handout to the group. Explain that the grid lists various sub-populations across the top row and their various survival/health/social service needs down the left side column. These categories can be changed as needed.
2. Instruct participants from the same communities to work together to fill in the grid. Others can work individually if necessary. Include as much specific information as possible.
3. Encourage participants to fill in all of the cells on the grid even if their primary focus is only on specific health concerns or certain sub-populations, for example, outreach to pregnant women or male intravenous drug users. In outreach it is important to be equipped with as much knowledge as possible about resource information for anyone the worker might encounter, even if briefly.
4. Suggest that workers carry this list with them and that they update it regularly as needed.

# Community Resources

	Youth	Families	Women	Men	Elderly	Spec. Pop.
Food/Meals						
Clothing/Gear						
Drop-in Center						
Shelter						
Health/MH/CD						
Financial						
Housing						
Education/Trg.						
Employment						
Crisis/Emerg.						
Other						

## **ACTIVITY 3 Accessing Emergency Services**

Purpose: To ensure that outreach workers are thoroughly familiar with various emergency services in the community and when and how to make use of them

Time: 10-15 minutes (longer is using alternative step #3)

Materials: A written resource sheet that describes various emergency services in the local community in which participants work. For example:

- Police
- Fire
- Emergency Medical Technicians (EMT's), paramedics, aid car, ambulance
- Hospital emergency rooms/departments
- Community health clinics
- Abuse/sexual assault/domestic violence/traumatic stress resources
- Crisis outreach/involuntary commitment services for mental health and/or substance abuse
- Detox vans
- Crisis Hot-lines
- Emergency shelter/housing, food, clothing

Preparation: Find an existing list of the emergency resources (see above) in your community that has as much detailed information as possible. Make a handout sheet or booklet for each participant. If you are unable to find a suitable or complete list, compile one yourself or consider making this a group activity (see procedure step#3).

### Procedure:

1. Explain the importance of being thoroughly knowledgeable about emergency resources and when and how to access them. Also, emphasize the importance of following up to find out what has happened with the individual who was referred for emergency care/services.
2. If you have come upon or created a comprehensive list to hand out to participants, take time to review the information there and discuss in detail when to access these emergency services, how to do so, and how to make follow-up contact.
3. Alternatively, if you choose to have the group participate in compiling this resource list, identify what services exist in the community and then create the list. You might assign individuals or small groups to obtain information about specific services. Have someone assemble and print the information so it can be distributed to the group. As in step #2, take time to review the list and discuss when and how to use the emergency services on it.

## **5C: Effective Referral and Linking**

### **Purpose**

The purpose of this section is to ensure that outreach workers understand the elements required for making successful referrals

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 Making Successful Referrals**

Purpose: To emphasize the required ingredients for making successful referrals

Time: 20 minutes

Materials: Handout: Checklist for Making Successful Referrals

Preparation: Be familiar with the handout, activity instructions, and be prepared to facilitate a group discussion.

Procedure:

1. Introduce the activity by noting that successful referrals in the HCH outreach context require more than giving someone a name, phone number, and wishing them good luck. As needed, review the various personal and systemic issues that hinder homeless people from accessing needed help.
2. Refer the group to the Checklist for Making Successful Referrals handout that has been created to remind workers of issues to consider in referring clients. You might choose to initially review the checklist with the group without much discussion, or simply move on to the next step.
3. Instruct each participant to think about a homeless client with whom they are working or have worked in the past. Have them identify a particular need (e.g. medical care, ID, public assistance, shelter/housing) for which a referral is required. Go through the checklist in order. Determine both the client's and the worker's readiness to make a successful referral. Factor in the client's readiness in regard to the Stages of Change Model (Module IV). What still needs to be learned or negotiated to prepare for a successful referral?
4. Facilitate a discussion with the group about what they observed about making successful referrals in the scenarios they reviewed. Any new insights? Issues to consider that are not on the checklist? Strategies to ensure clients make it to appointments? Thoughts about how to use the checklist as a visual reminder in the office?



# Checklist for Making Successful Referrals

- I have an adequate understanding of the client's situation and perceived needs.
- The client and I have talked about how to prioritize these needs and what options exist to help address them.
- He or she is willing and ready to be referred.
- We have discussed competing issues that might hinder the client from following through with a referral.
- I am familiar with the agency to which I am referring the individual, including its eligibility requirements and services?
- The agency has the *ability* and *willingness* to serve homeless people in a knowledgeable and respectful manner.
- I have a working relationship with at least one staff person at this agency who can provide useful information and help advocate for the client.
- I have considered whether or not to accompany the client based on the individual's:
  - Ability to negotiate complex social situations
  - Ability to provide and receive information
  - Ability to tolerate waiting
  - Level of ambivalence about seeking help
  - Interpersonal style (passive to argumentative)
- If the client is going alone, I have provided sufficient information and "coaching" to help make the referral successful?
- I have made a plan to follow up with the client to see how things went and to determine next steps?

References: Long and Jacobs (1980:4-32--4-33); Schutt and Garrett (1992:61-64); Wood (1992:41-42)

## **ACTIVITY 2 Referral Role-plays**

Purpose: To practice skills in dealing with various referral situations

Time: 25 minutes

Materials: flipchart, marker

Preparation: Review and plan ahead for carrying out the steps of the activity.

Procedure:

1. Explain the purpose of the activity and the value of practicing responses to various scenarios that might occur.
  
2. Ask the group to brainstorm for about five minutes about various “sticky situations” they might encounter when going along with a client to see someone at a referral site. Write these on a flipchart. Encourage participants to be as specific as possible. If needed, prompt them with some of the following examples:
  - The client refuses to cooperate, e.g. will not give needed information or sign any paperwork
  - The person to whom the client is being referred treats the client in a paternalistic manner, directing his/her statements to you as the worker instead of the client
  - The client is too confused or psychotic to track what is going on
  - Despite having a set appointment, the client and you have been waiting for forty minutes past the time. The client is oblivious to this but you are becoming very irritable.
  - The person to whom the client is being referred shows not-so-subtle fear and contempt towards the client
  - The client is angry, hostile towards the receptionist who becomes very flustered and upset
  
3. Have the group choose three of these scenarios to role-play.
  
4. Divide into small groups of three. Each person in the group will take turns playing the role of 1) outreach worker, 2) homeless client, and 3) the person/agency to whom the client is being referred.
  
5. Instruct the groups to role-play each of the three scenarios, rotating roles for each of the three so that each participant plays all three roles. Allot approximately 15 minutes to complete the three role-play scenarios.
  
6. Close the activity by taking time to discuss what issues and insights came up during the role-plays.

## **ACTIVITY 3 Establishing Clear Working Relationships with Other Agencies**

Purpose: To establish clear and mutually agreed upon working relationships with other agencies through the use of a memorandum of agreement (MOA)

Time: 15 minutes

Materials: Handout: Sample Memorandum of Agreement

Preparation: Review the sample MOA in the handout and other inter-agency agreements to which you have access, especially from organizations represented by participants.

Procedure:

1. Review the purpose and value for outreach workers to have a written memorandum of agreement with other agencies in which they work, have frequent contact (e.g. shelters, drop-in sites), or to which they make referrals. In some cases other agencies will agree to give priority to referrals made by your program or provide other specialized services.
2. Review the sample MOA on the handout with the group and/or any other agreements you might wish to examine. Invite questions or comments for discussion. Urge participants to think about agreements they *wish* they had with other agencies and how such agreements might be reached.
3. Encourage participants to review existing written interagency agreements in their own work settings that apply to them. Suggest that if none exist they discuss this matter with their supervisors and team to determine the value and importance of creating an MOA with other sites.

## **SAMPLE MEMORANDUM OF AGREEMENT**

This agreement is entered into as of this \_\_\_ day of May 2002, by and between HOMETOWN HEALTH CARE FOR THE HOMELESS INC. (hereinafter HCH) and RESCUE MISSION, THE GOOD SHEPHERD CENTER and SALVATION ARMY (hereinafter referred to as The Shelters).

### **RECITALS:**

1. In as much as HCH currently provides a full array of primary care services consisting of on-site medical and dental services, as well as behavioral health services, to over 6000 unduplicated homeless clients in the Hometown metropolitan area per year, the agency believes that in order to provide accessible health care to all segments of the homeless population that it must intensify its primary care and behavioral health outreach activities to new access points in the area where the homeless population concentrates.
2. The above mentioned ministries or social service agencies by their location form a cluster of supportive services to the homeless population that includes meals and shelter for a large portion of the homeless population. These agencies have an interest in linking their clients to accessible quality health care and social services in the city, recognizing the multiplicity of needs that the homeless population presents each day. Furthermore, these agencies have resources and available space so that these services can be provided.
3. As part of a new funding opportunity provided by the Department of Health and Human Services, Public Health Service, Bureau of Primary Care, HCH has the opportunity to develop a new initiative which will enable it to extend primary care and behavioral health services to "new access" points and to under-served segments of the homeless populations which include intravenous drug users, homeless teens, and certain under-served minority populations most notably African-American and Native American groups.
4. The four agencies believe that it is in the best interests of their clients to share resources and to collaborate in the delivery of services, and in so doing, the agencies will achieve a synergy of positive results and benefits that improve the lives of their clients.

### **IT IS, THEREFORE, AGREED AS FOLLOWS:**

#### **THE SHELTERS SHALL:**

1. Designate quiet space on the premises of the Shelter where an HCH medical provider team and behavioral health outreach workers will set up clinical care activity at least two days per week to permit clients of the Shelters to seek consultations with these providers.

2. Staff at each Shelter will provide verbal and written notice and information clients on their sites regarding the scheduled clinic hours.
3. Staff will provide regular feedback to the HCH provider team regarding the input from clients as to the quality and benefit of medical care.

**HCH SHALL:**

1. Provide at least two outreach primary care clinics of 4-6 hours duration at each of the shelters in the cluster. The primary care medical team will consist of at least a physician or mid level nurse practitioner who will be assisted by a Registered Nurse or Licensed Practical Nurse. Behavioral health outreach and engagement services will be provided by at least one outreach worker specially trained to engage difficult to reach clients in the shelter. The types of services to be provided by the outreach activity will be determined in part by the needs of clients but will generally fall into categories of activity that are listed in appendix A. Care that cannot be provided on site will be referred to the HCH Medical or Dental Clinics or University Hospital Emergency or Urgent Care.
2. Provide the regular schedule of outreach clinic activities for the month, as well as any necessary revisions to the schedule, to the staff of the shelters at least 10 days prior to the end of the prior month so that clients are appropriately advised.
3. HCH assumes complete responsibility for the quality of primary care services and the ethical and professional conduct of its providers during the time they are providing services on the premises of the Shelter Cluster.

**ALL PARTIES SHALL:**

1. Designate a contact person for referral and communication of issues and notify the other parties who the person is and how to contact them by mail, telephone, email, and fax.
2. Give a minimum of two weeks written notice of intent to terminate this Agreement, unless such termination is by mutual consent.

Rescue Mission

\_\_\_\_\_  
By: (name of signer)

Salvation Army

\_\_\_\_\_  
By: (name of signer)

The Good Shepherd Center

\_\_\_\_\_  
By: (name of signer)

Health Care for the Homeless

\_\_\_\_\_  
By: (name of signer)

(Adapted from Albuquerque Health Care for the Homeless Inc.)

## **5D: The Outreach Worker as Advocate**

### **Purpose**

To acknowledge the integral role of advocacy in outreach and to explore its implications

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **Introduction**

Outreach and advocacy are inseparable activities. Outreach itself is advocacy. It is a conscious act initiated on behalf of others. The term advocacy comes from the Latin "advocare" which literally means to speak to or call out. We advocate of course not only with our voices but also with our actions.

Advocacy happens. Sometimes it is what outreach workers do without calling it such. It often happens on a relatively small scale on behalf of an individual client – making a positive comment about homeless people to a shopkeeper, introducing a homeless person to someone at a drop-in center, helping someone get a bed at the shelter. On a larger scale systems advocacy can produce results affecting whole groups of people such as creating new programs or removing barriers to care.

There is often a perception among social service workers that "real" advocacy is somehow a separate activity to be conducted by "experts." While such people are needed, nonetheless advocacy is the responsibility of us all. Oftentimes, no matter the audience, advocacy is most compelling when it involves speaking from direct experience. This is especially true for the person who has experienced homelessness and for workers who have witnessed homelessness in their walk with others.

Outreach workers who overtly identify themselves as "outreach worker-advocates" are more likely to see the centrality of advocacy in their work. These same workers are also likely to experience burnout less quickly because of their ability to maintain hope through advocacy efforts. Advocacy can sometimes be very frustrating of course and seemingly fruitless, but when even small successes occur, there is cause for celebration which is always a good source of renewal.

Advocacy does not come easy for many, especially those who like to be liked. By its very nature advocacy often puts one at odds with another. It can create tension and conflict especially when confronting rigid systems and people who are inflexible. Being an advocate requires courage as opposed to bravado. Courage flows from the worker who has clarity of purpose, credibility and does not seek personal gain. The individual who sees advocacy as a personal battle operates with the "false courage" of bravado. Workers need to refrain from making advocacy a personalized fight. When we work for justice, we are compelled to act justly.

## ACTIVITY 1 Advocacy Brainstorm

**Advocate** (n.) – from the root word *vocare*: to call, summon;  
one that pleads the cause of another;  
one that defends or maintains a cause or proposal  
(Merriam-Webster Collegiate Dictionary)

Purpose: To explore the concept and activities of advocacy in outreach

Time: 15-20 minutes

Materials: Flipchart and markers

Preparation: For background reading, review the material in the introduction above. In addition go to <http://www.nhchc.org/advocacy.html> and click on Introduction to Health Care for the Homeless Advocacy and State & Local Advocacy by HCH Projects.

Procedure:

1. Have the group explore advocacy through a brainstorming exercise. Ask the following questions one at a time and write down the key ideas on a flipchart. Allow time for as many responses as the group has. Be sure to encourage the more timid individuals to share their ideas.

- How do you define advocacy?
- What are some ways in which children, from infancy to adolescence, advocate for themselves?
- What are some ways that you have advocated for yourself recently? Give examples both within and outside your work setting.
- What are the various ways in which you do advocacy in your current outreach work? Be sure to include the small details and actions you perform.

2. Summarize by noting that advocacy is very much a part of our lives and occurs in many ways at various levels. For outreach workers, advocacy is absolutely integral to the work. Outreach itself is advocacy.



## **ACTIVITY 2 What is Advocacy in the HCH Context?**

Purpose: To understand the “who, what, where, how, and why” of advocacy in the Health Care for the Homeless context

Time: 30-45 minutes

Materials:

Handout: From Individual Advocacy to Policy Advocacy

Handout: What Does HCH Advocacy Look Like?

Preparation:

Go to <http://www.nhchc.org/advocacy.html> and click on Introduction to Health Care for the Homeless Advocacy and State & Local Advocacy by HCH Projects for background reading on HCH and advocacy.

Prepare a presentation to give to the group based on the materials at the website above. A basic outline might include the following topics:

- Why is advocacy needed?
- What is advocacy?
- What is policy?
- How does one shift from individual to “policy” advocacy?
- Who makes policy?
- What does HCH advocacy look like?
- Who should “do advocacy?”
- How does one integrate service and advocacy?
- What are some examples of state and local advocacy by HCH projects?

Procedure:

1. Give a 20-25 minute presentation on advocacy in the HCH context. Use the handouts to augment your presentation. Illustrate various points with your own advocacy experience.

2. Invite participants to visit the website at <http://www.nhchc.org/advocacy.html> for further reading and ideas about doing advocacy.

## From Individual Advocacy to Policy Advocacy

**Advocate** (n.) – from the root word *vocare*: to call, summon; one that pleads the cause of another; one that defends or maintains a cause or proposal (Merriam-Webster Collegiate Dictionary)

Individual Advocacy	Policy Advocacy
Mr. Johnson is in a wheelchair and was evicted from his home for failure to pay rent; most shelters in the city are not wheelchair accessible; an HCH worker calls to convince a shelter to allow him to stay.	The Federal Fair Housing Act and the American with Disabilities Act have never been applied to shelters in this city. HCH staff propose that shelter resources be made available to accommodate individuals with disabilities.
Ms. Foster is in need of detoxification from alcohol. Though space is not available, an HCH worker calls unsuccessfully to convince a center to make an exception. The next day, detox is no longer a priority for the client.	HCH staff organize a coalition of addiction providers, concerned citizens, and public health advocates to assure that opportunities for detoxification and treatment are expanded to meet current need.
Mrs. Jenkins has used all of her food stamps and needs food for her family for the weekend. An HCH worker locates a food pantry which provides a bag of groceries.	HCH staff join with other "hunger" activists to advocate that food stamp levels be increased so recipients are able to feed their families.
Mr. Warren came to an HCH clinic because he lost his insurance after losing his job due to a disability. The HCH doctor spends days seeking a surgeon who will treat Mr. Warren pro bono.	HCH staff join the Health Care for All Coalition to create universal health insurance in their state.

(From State and Local Advocacy Manual (S.L.A.M.) – National Health Care for the Homeless Council. For additional information, go to <http://www.nhchc.org/advocacy.html>.)

# WHAT DOES HCH ADVOCACY LOOK LIKE?

*Contrary to the stereotypical images of lobbyists in smoke-filled rooms wheeling and dealing with legislators, advocacy in the HCH context consists of finding effective ways to inform policy-makers about issues concerning homelessness and health.*

1. **EDUCATION:** First of all, it is important to have accurate, up-to-date information on the issue in question and that supports the position you are taking.
  - This is where the results of different kinds of evaluation studies can prove useful.
  - It is also valuable to have data that have been collected from more than one HCH project, for example, studies on the effects of managed care on homeless people or the effects of changes in SSI legislation. Data of this type, once collected, can be published in reports with copies sent to policymakers, as well as the media.
  
2. **USE OF MEDIA:** Media advocacy can be a powerful tool for disseminating information and garnering public support for your position.
  - The simplest form of interaction with the media is probably a letter to the editor, responding to a recent local or national situation that relates to your issue.
  - An "op-ed" is a longer article on the editorial page that offers an opportunity to present more detail regarding the issue, providing examples from your own project and/or national studies.
  - If the issue is timely and considered "newsworthy," it is also possible to get media representatives to develop a human interest story that illustrates the point you want to make.

(An important caveat regarding media advocacy is that your organization's position on the issue in question must be clear, and in some cases formally approved by your governing body. An individual staff person with a microphone in front of him/her expressing his/her own personal opinion regarding the issue — which may or may not be well-informed or accepted by others in the organization — can sometimes do more harm than good.)

3. **CLEAR POSITION STATEMENTS:** It is better to proactively develop clear position statements for the organization, than to try to reactively do damage control later.
  - It is also helpful for the organization to identify the spokespeople for particular issues. It may be that the executive director is the most appropriate person to respond to a legislative issue, but the medical director is the spokesperson for questions regarding health care issues.
  - However it is configured, all staff and board/advisory committee members should be aware of who the spokespeople are, in case they are contacted by the media.

4. **DIRECT INTERACTION:** In terms of direct interaction with policy-makers, there are several strategies useful for HCH projects.
- **Don't Wait - Start Now:** A basic principle from the "friend-raising" approach is that you should not wait until there is a problem or even a particular issue to address before getting to know your legislators or the appropriate administrators at all levels of government.
  - **Schedule a Visit:** An introductory visit just to let the person know about your project - what services you provide, where you provide them, who your clients are, etc. - will lay the foundation ahead of time for a helpful response when you need to contact the person regarding a particular problem or issue.
  - **Issue an Invitation:** Even more effective than visiting the policy-maker's office is inviting that person to tour your project. Seeing first-hand what you do will leave a stronger impression than even the most compelling fact sheet or beautiful brochure.
  - **Subsequent contact** with a policy-maker's office may then be either in person - group visits from staff, clients and board members are effective with legislators - or through phone calls, letters or faxes. Some of this contact may be the result of an individual project's issues, or in response to action alerts sent out by local, state or national advocacy groups.
  - **Develop a System:** With regard to the latter, it is helpful to have some kind of network in place for responding quickly to such alerts. Phone trees, fax trees, etc. are common approaches to moving the information quickly and allowing for a rapid response to breaking issues.
  - **Testify:** HCH staff may also be asked to provide their expertise during the legislative or rule-making process. This could entail testifying in front of a legislative committee or at a regulatory hearing.
  - **Draft Legislation:** If you have a good working relationship with legislative or administrative staff, you may even be asked to assist with drafting legislation or regulations, or to review and comment on drafts before release.

**Throughout all of these advocacy activities, it should never be forgotten that being polite and respectful will go a long way toward developing productive working relationships that result in support for your issues.**

(From State and Local Advocacy Manual (S.L.A.M.) – National Health Care for the Homeless Council. For additional information, go to <http://www.nhchc.org/advocacy.html>.)

## **ACTIVITY 3 Making Advocacy Work in Your Work**

Purpose: To develop recommendations for outreach programs to promote advocacy as an integral aspect of care

Time: 30-45 minutes

Materials: Handout: Tips for Integrating Direct Service and Advocacy at Your Agency

Preparation:

Review the handout and be familiar with the activity instructions below.

Procedure:

1. Break into small groups of approximately four to six participants. Each group's task is to create a strategy to promote advocacy as a vital part of the agency's mission goals, and services it provides. This recommended strategy is to be presented for consideration at an agency-wide meeting that will include staff, administrators, the Board of Directors, and some current and/or formerly homeless clients.

2. Instruct each group to take about 10-15 minutes to brainstorm ideas. Encourage them to think about a range of advocacy ideas and activities that are directed towards policy and structural issues as well as those that address individual client needs. Some ideas might have to do with activities in regard to specific issues (e.g. housing, access to treatment) while others will be more general (e.g. participating in the local homeless coalition, adding systems advocacy to workers' job description).

3. After this period of brainstorming, each group is given another 10-15 minutes to create a presentation for the agency-wide meeting. This presentation is to highlight three to five key recommendations for how the organization might promote advocacy at the service and systems levels. The presentations are to meet the following criteria:

- All or most members of the group should be included in the presentation.
- It is to be interesting and imaginative, not boring! (The use of skits, songs, limericks, haiku, games, role-plays, etc. is highly encouraged.)
- The content of the presentation should include approximately 3-5 specific activities for implementation.
- The presentation should take no more than five minutes.

4. Have the small groups make their presentations to the agency-wide meeting attendees. Either after each presentation, or after they've all been given, allow time for questions and comments from the audience. Ensure questions are asked by various people in attendance who represent outreach workers, clients, supervisors, Board members, etc.

5. Discuss the most viable ideas that have been raised and challenge participants to consider ways to implement them in their own work settings.

6. Conclude the activity by distributing the handout that provides tips for integrating direct service and advocacy in the agency setting. This can be used as a supplement to the ideas that were raised in the course of the activity.

## Tips for Integrating Direct Service and Advocacy at Your Agency

*Integrating service delivery and advocacy requires at least a modicum of staff education, a great deal of staff "buy-in" and administrative support, and an extra helping of patience. The following tips provide useful strategies for incorporating advocacy into the very form and structure of your organization.*

- **Incorporate a commitment to advocacy into the agency's mission statement.** If you haven't already done so, bring up this issue at an upcoming next board meeting.
- **Involve HCH clients** in the project's board or advisory committee, and/or board committees that address advocacy issues, e.g., Government Relations or Public Policy Committee.
- **Involve staff** in the board committees that address advocacy issues. Have them serve as "staff" to the committee, assisting in setting the agenda, preparing minutes, etc.
- **Develop a yearly Advocacy Agenda** to define the major issues upon which the agency intends to focus. Staff, clients, and board/advisory committee members should participate in its development and the board/advisory committee should formally adopt it. Assign responsibility to individuals or teams for each section of the plan.
- **Set aside time at each staff meeting** and board/advisory committee meeting to discuss progress on the Advocacy Agenda, as well as other emerging advocacy issues.
- **Include advocacy in the job descriptions** of service providers. For example, you might require that 5 percent of the time of each provider will be devoted to advocacy.
- **Incorporate advocacy issues into new staff orientation.** Present to new staff relevant local, state, and national policy concerns and advocacy initiatives.
- **Involve staff and clients directly in advocacy opportunities.** Within reason, and without disrupting services, staff should have the opportunity to represent the agency on external boards, committees, work groups, and coalitions. Maintaining a frequently updated list and receiving reports from staff on this community participation assists in the identification of staff who may be under- or over-committed, duplication of effort (or contradictory efforts), and issue areas that may need more attention.
- **Involve staff, clients and board/advisory committee members** in response networks for telephone calls, faxes, and letter-writing campaigns.
- **Join local, state, or national homeless coalitions,** health care/welfare coalitions, and primary care associations.
- **Subscribe to the HCH Mobilizer.** Distribute it to clients, staff and board members. Use the Mobilizer section of this binder to store your Mobilizers and advocacy responses.

(From State and Local Advocacy Manual (S.L.A.M.) – National Health Care for the Homeless Council. For additional information, go to <http://www.nhchc.org/advocacy.html>.)

## ACTIVITY 4 Charity or Justice?

"Charity offends almost no one;  
at one point or another,  
justice offends practically everyone."

David Hilfiker, *The Other Side* magazine, Sept and Oct 2000

"Homelessness is a prism that refracts society's most vexing problems,  
and the solution will require fundamental reform  
in housing, health care, welfare, education, and corrections."

James J. O'Connell, *Harvard Medical Alumni Bulletin*, Summer 2000

Purpose: To reflect on the goals and implications of different forms of advocacy in outreach

Time: 20-25 minutes

Materials: Handout: Charity or Justice?

Preparation: Read and reflect on the handout which is intended as a discussion document.

Procedure:

1. Distribute the handout to participants. Explain that it is intended as a discussion document to reflect on the goals and implications of different forms of advocacy in outreach. Have someone read the handout aloud to the group.
2. Ask for participants' reactions to the paper and facilitate a discussion with the group. Some questions you might pose:
  - In what ways do you agree or not agree with Hilfiker's comments about charity and justice – and why?
  - How does Hilfiker's description of charity and justice help to inform and/or challenge your thinking about advocacy? About the work you do?
  - What opportunities exist within and outside your work life to be involved in policy and systems-level advocacy?
  - What are factors that might limit your involvement in advocacy on the job?
  - How can educating be a form of advocacy?



# Charity or Justice?

"Charity offends almost no one;  
at one point or another,  
justice offends practically everyone."  
– David Hilfiker

Outreach workers are in a unique position to advocate authentically and powerfully on behalf of people experiencing homelessness. The experience of doing outreach work generates compelling first-hand observations, anecdotes, and analyses that beg to be imparted to a broader audience, especially to decision-makers from supervisors to legislators. Just as it is essential in outreach to listen to people's stories, so it is imperative to "tell the story" of homelessness to the broader human community in which we live.

Outreach and advocacy are inseparable activities. Outreach itself is advocacy in action. Outreach workers are particularly skilled and experienced in "calling out for and on behalf of" individuals experiencing homelessness. But how far are we to take advocacy? Do we dare challenge the conditions and policies that deprive whole groups of people of health and home? Do we have the courage to call out for justice in our social structures, while still helping to restore what is broken in the lives of the individuals for whom we care?

Providers who work with homeless people encounter an uneasy tension concerning the difference between doing "charity" and "justice." David Hilfiker ("The Limits of Charity" in *The Other Side* magazine, September and October 2000) describes this tension as such: "Justice has to do with fairness, with what people deserve. It results from social structures that guarantee moral rights. Charity has to do with benevolence or generosity. It results from people's good will and can be withdrawn whenever they choose."

Hilfiker argues that charity must be viewed as a limited response. It may be a necessary response in our current situation, but it is not enough. Charitable organizations, including government-sponsored programs, provide important services and care but are rightly seen as a "safety net" – not the *solution* to the concerns of poverty and homelessness.

Hilfiker argues that "charity does little to change the wider social and political systems that sustain injustice." Instead, charity "acts out" inequality. It maintains the system of "we who are the givers and *they* who are the receivers." It does not address the fundamental conditions of injustice – the inevitable result of the structures of our society – that are at the root of poverty and homelessness.

Ken Kraybill

# **Module 6:**

# **MUTUALITY**

## **Coming Home**

### **Purpose**

The purpose of Module 6 is to enhance outreach workers' appreciation of the meaning of having a home, to identify approaches to assist homeless individuals in "coming home" within themselves, in their housing, and in the community, and to prepare for the transition and closure phase of the worker-client relationship.

## 6A: The Meaning of Home

“Home is where we start from, but home is also where we are bound for, the place we always seek.”

– David Steindl-Rast

### **Purpose**

To increase understanding of the importance and meaning of having a home

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 The Meaning of Home**

Purpose: To help participants appreciate the importance of having a “home” ... and the impact of its absence

Time: 15 minutes

Materials: Paper and pens

### Preparation:

The mutuality phase in the Relational Outreach and Engagement Model is characterized by a “coming home” in the various dimensions of one’s life. When basic survival needs have been met, when relative stability has been achieved in housing, income, and access to needed services, and when companionship has been multiplied to include various providers, family members and friends forming a “circle of care,” then one can more readily explore the deeper questions that life presents.

Craig Rennebohm states: “You know you are in the mutuality phase when people are raising questions regarding intimacy, relationships, vocation, faith, and so forth.” In those circumstances when outreach workers have the opportunity to extend their work with clients into the mutuality phase of relationship, they need to be prepared to assist them in examining these issues. These concerns are the building blocks of making a house into a home. Though none of us ever feel completely “at home” in the various dimensions of our lives, we all strive for such an experience.

This exercise attempts to accentuate the significant role and meaning that home plays in our lives. By simulating at a personal level what it would be like to lose various aspects of home, it is hoped that participants will develop a deeper appreciation for both having a home and what it means to be without a home, or home-less.

Many people who become homeless do so gradually over time. They experience losses in a cumulative manner causing them to spiral downward into homelessness. These losses often include jobs, relationships, health, and finally housing. For others homelessness happens rather precipitously usually due to a major tragedy. And there are yet others we meet who have never really experienced having a home to lose. For them, home is unfamiliar territory, an alien idea. Yet the idea of home seems to be a universally powerful concept no matter what one’s experience has been. The intent of this exercise is to explore in a small way the power of the idea of home.

### Procedure:

1. Instruct participants to fold a blank sheet of paper into quarters.

2. Ask each person to identify the four most important things that having a home means to them. For example, a place to “be yourself,” a place of protection, a place to be with your loved ones, a place to rejuvenate, etc. Write one each of these four responses on the quarter sections of the paper.
3. Next, announce that due to an unforeseen circumstance, one of these valued aspects of home is taken away. Instruct participants to tear away one of the quarter sheets, whichever characteristic of home they could imagine parting with most readily.
4. Soon thereafter another tragic event occurs resulting in another aspect of home (quarter sheet) being removed.
5. Repeat this scenario so that the participant is left holding only one of the quarter sheets. This sheet will contain the aspect of home that the individual values most.
6. Discuss and debrief this exercise by asking questions such as:
  - What did it feel like to do this exercise? Did you resist it?
  - How did you make the choices you made?
  - What did you lose each time and what was it like to imagine that happening?
  - What was the last thing you were able to hold on to? (This is one of the most highly valued characteristics of home for you.)
  - How do people experiencing homelessness try to re-create some of these aspects of home?

*(Thanks to the Bay Area Homelessness Program, San Francisco for the idea of this exercise.)*

## **ACTIVITY 2 What Makes a House a Home?**

Purpose: To explore the connection between the structural aspects of a house and the symbolic meaning of those structures that “make a house a home.”

Time: 15 minutes

Materials: Flipchart and marker

Preparation: Review the procedure below.

### Procedure:

1. On a flipchart draw a simple two-dimensional image of a house with roof, walls, foundation, door, windows, and chimney. Participants can imagine the inner rooms of the house. (This image of a house is used for instructional purposes with recognition that it does not fit the reality of most housing available to low-income people.)

2. One at a time, identify different structures of the house and ask what function they serve and what do they symbolize in regard to making a house into a home. For example: “What function does a roof have?” “What does a roof symbolize?”

Below is a sampling of responses that participants might make:

- Roof – shelter, protection from the elements, safety, security
- Outer walls – protection, privacy, safety, separateness, strength
- Foundation – solid footing, stability, predictability, permanence
- Chimney – warmth, “letting off steam”
- Doors – arriving and leaving, welcoming guests, privacy, security
- Windows – letting in light, connection with the outside world, awareness, perspective
- Living room – relaxation, socialization, playfulness, entertainment, hospitality
- Kitchen – nutrition, nurturance, creativity, emotional security
- Bedroom – rest, quiet, sleep, intimacy, privacy, awakening
- Bathroom – personal hygiene, body awareness, appearance
- Personal space – reflection, meditation, retreat, solitude
- Closet – storing belongings, secrets, memories
- Other

3. Close the activity by inviting participants to share any comments or insights that might have come up during this activity. Provide a reminder of the crucial connection between having housing in order to have a home and the importance of having a home in order to live in a stable and satisfactory manner.

## **6B: Three Homes**

### **Purpose**

To explore the concept of the “three homes” of our lives – the self, one’s living space, and the larger community – and to identify ways to help clients become more “at home” in these three dimensions

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants’ learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 The Three Homes of our Lives**

**Purpose:** To explore the richness of the concept of home and point to the role of outreach in helping people move towards “home” in three dimensions

**Time:** 30 minutes

**Materials:** Handout: Three Homes

**Preparation:**

Read the handout in advance and become familiar with its content. It is preferable that participants also read it in advance of the session.

**Procedure:**

1. Provide an overview of the “three homes” concept, assuming participants have read the handout in advance. (If not, consider reading it as part of the activity).
2. Solicit participants’ comments about the usefulness of thinking about “home” in these three dimensions.
3. Engage in a more in-depth discussion by posing the following questions:
  - In the past twenty-four hours, what specific activities have you undertaken that relate to the care and maintenance of your “first home”? Your “second home”? Your “third home”?
  - How would your ability to carry out these activities be affected if you were living in a shelter or on the street?
  - What are some specific ways that you might assist a person experiencing homelessness to feel increasingly “at home” in their first, second, and third homes? (Also see Activities 2-4 in this section.)



# Three Homes

*Home: one's place of residence, domicile, house, the social unit formed by a family living together, a familiar or usual setting, congenial environment, the focus of one's domestic attention (home is where the heart is), habitat, a place of origin (salmon returning to their home to spawn), headquarters, an establishment providing residence and care for people with special needs, the objective in various games, out of jeopardy, in a comfortable position with respect to some objective, to a vital sensitive core (the truth struck home) At home: relaxed and comfortable, at ease (felt completely at home on the stage), in harmony with the surroundings, knowledgeable (teachers at home in their subject fields), on familiar ground*

Each of us "resides" in three homes.

The **first home** is the self – one's primary home. This is the home of our very being and identity. The fundamental characteristics of this first home are physical, mental, emotional, social and spiritual in nature.

This home must be kept warm, dry, safe and in good working order. It needs exercise, rest, nutrition and proper maintenance. It also needs to be nurtured and maintained through intellectual stimulation, emotional support, behavioral regulation, time for reflection and development of a sense of purpose and meaning in connection to the outer world.

We receive our first home at birth. Early in our lives, others are given primary care-taking responsibility for our care and nurture. Gradually we come to claim more of this responsibility for ourselves.

Although we are wonderfully and complexly made with the ability to do great things, we are also created with considerable fragility and vulnerability. Even the strongest among us experience great frailty at times. Each of us requires the sustaining efforts of others in order to thrive. Despite our best self-care efforts, we still need the knowledgeable care, love and support that others can provide.

Our **second home** is that with which we are most familiar – the place where we live, our housing, where we "nest." It refers not only to the physical structure in which we live but to the kind of living environment we create within it.

Like the first home, this home possesses important physical, mental, emotional, social and spiritual characteristics. It offers safety and protection from the elements and the outside world. It provides an adequate, private space in which to properly attend to hygiene, rest, and nutrition needs.

This home serves as a base of operations and a place to keep and use one's possessions. It offers a place of welcome, familiarity, and stability. In this home we can welcome guests, share in celebration and suffering, be creative and silly, be still and mindful, be intimate with loved ones and find renewal of energy and purpose.

The very structure and design of typical housing in our cultural context points to these functions. For example, we construct a foundation (stability, grounding), walls (protection, privacy), a roof (shelter, protection from the elements), doors (welcoming, shutting out), and windows (light, connection with the outside world).

Space is divided into a living room (relaxation, socialization, play), kitchen (hospitality, nutrition), bedroom (rest, intimacy), bathroom (hygiene), study (intellectual stimulation, meditation), closets (secrets), and a yard/garden (play, relaxation). This second home provides the necessary context for meeting the needs of the first home and an important foundation and link to the third home.

The **third home** in which we reside is the larger community, or more accurately, the multiple communities, from the local to the global, in which we are located. Here our interdependence with other people and organizations is fully evident. It is in the context of these various communities that we fulfill various roles and participate in the life around us. We give and receive, produce and consume, lead and follow, serve and are served.

There are numerous opportunities for participation and resources in this third home that permit us to meet the needs of our first and second homes. For example, it is in the context of the larger community that we are connected to health care, education, work, food procurement, transportation, socialization, purchasing goods, entertainment, the arts, politics, recreation and community service. This third home provides the social, economic, service and cultural context for our lives.

**What implications** does this notion of “three homes” have for outreach workers? People on the streets often do not feel “at home” in their own bodies, minds, and souls, have no housing to call home, and are disaffiliated from a meaningful role and purpose in the larger community.

It seems clear that if we want to help people resolve their home-lessness, then we are compelled to aim our efforts beyond helping people to meet basic survival and health needs or even moving them into housing. As the saying goes, a house is not a home. We must assist them in making their housing into a home. In addition, we must also help them be more attuned to their own personal conditions, needs and care. And we must help them find their “place” in the larger community.

Helping others move towards a greater sense of being “at home” in their lives begins with the very first outreach encounter. For example, by offering a hospitable presence – “creating a free and friendly space for the stranger” (Nouwen) – one makes it possible for the other person to experience a taste of being “at home.” The seeds planted in such a relationship can go a long way to help someone take the necessary steps towards greater stability in all three homes of their lives.

Ken Kraybill

## **ACTIVITY 2 First Home: Developing a Healthier Self**

*Note: Activities 2-4 explore each of the “three homes” in greater detail than in Activity 1. It is recommended that these three activities be presented as a “package” in order for the training to be most effective.*

Purpose: To identify specific ways for outreach workers to encourage clients to become more “at home” in the physical, intellectual, spiritual, and social aspects of their lives

Time: 15-20 minutes

Materials: Handout: “Healthier Self” Care Plan

### Preparation:

Review the Three Homes handout from Activity 1 in this section, paying particular attention to the section on the “first home.” Also, review the Self-Assessment Tool: Self-Care handout from Module 2B.

Review and consider completing the “Healthier Self” Care Plan handout for yourself as a way of preparing for this activity.

### Procedure:

1. Provide a brief review as needed regarding the notion of the “first home” and state the purpose of this activity as noted above.
2. Distribute the handout to all participants. Explain that this form can be used as a tool to help clients address some of the issues related to their own self-care care once they have achieved relative stability in their lives, especially in housing, income, and access to needed health and social services.
3. Divide the group into pairs. One partner assumes the role of the outreach worker and the other is the client who is fairly stable but with limited resources. The two simulate a conversation that might occur in the mutuality phase of relationship in which they are working together on a self-care plan for the client. The worker is to facilitate the process in a client-centered manner. Have the client complete the form in writing in his/her own words. The worker can provide ideas and comments as appropriate. Allow 8-10 minutes for this step.
4. Bring the group back together and discuss briefly how this tool, or a similar process, might be used most effectively for the benefit of clients in the mutuality phase of the outreach and engagement relationship.

# "Healthier Self" Care Plan

Month of \_\_\_\_\_

**Instructions:** The intent of creating this plan is to spark ideas to take good care of yourself and to identify steps to put your ideas into action. Use the plan as a guide. Consider reviewing/updating it each month. Be specific in listing each activity you want to do, when or how often you will do it, and the preparation steps it will require. For example: "Walk one mile a day – five mornings a week – determine route, need good shoes, walking stick."

## Activity

## When/How Often

## Steps Needed

**Physical** (hygiene, exercise, nutrition, sleep, health care, stress reduction, etc.)

1.

2.

3.

4.

**Intellectual** (take a class, read newspaper, literature, write, learn a hobby, visit museums, exhibits, etc.)

1.

2.

3.

4.

**Spiritual** (meditate, pray, enjoy nature, journal, sing, religious participation, etc.)

1.

2.

3.

4.

**Social** (coffee with a friend, recreational events, join a club/organization, etc.)

1.

2.

3.

4.

## **ACTIVITY 3 Second Home: Making a House a Home**

*Note: Activities 2-4 explore each of the “three homes” in greater detail than in Activity 1. It is recommended that these three activities be presented as a “package” in order for the training to be most effective.*

Purpose: To identify areas in which outreach workers can assist clients in becoming more “at home” in their own living space/housing.

Time: 15-20 minutes

Materials:

Handout: Making a House a Home – A through Z  
Prizes for contest winners

Preparation:

Review the Three Homes handout from Activity 1 in this section, paying particular attention to the section on the “second home.” Take a look at the Making a House a Home handout and consider filling it out yourself to become familiar with the activity.

Procedure:

1. Provide a brief review as needed regarding the notion of the “second home” and state the purpose of this activity as noted above. Emphasize that maintaining housing and creating a nurturing living environment requires a great deal of time, energy, and creativity. Workers who have the opportunity to continue relating to clients who are stably housed can assist clients in developing this “second home.”
2. Set up a contest in which teams (pairs or small groups of participants) compete with one another. Distribute one handout to each team. The idea is for each team to write down as many items or functions that they can think of per the instructions on the handout. Teams are given a limited time period for the contest – approximately 5 minutes (or shorter or longer as desired).
3. At the end of the timed contest, give out various frivolous or inexpensive prizes to teams for such things as: greatest number of items A through Z, most ridiculous response, most creative answer, best response for the letters X, Y, and Z, and so forth. Have fun with it!
4. Close the activity by reminding participants that in the mutuality phase it is important to explore with clients how things are going with maintaining their housing and creating a safe, nurturing living space. This may also include talking about client’s intimacy needs and close relationships. Use this activity as a reminder to discuss these matters with clients not only in general terms, but also in detail as appropriate.

## Making a House a Home – A Through Z

Identify various items or functions that contribute to maintaining one's housing and creating a home environment. Be creative. List as many of these as you can for each letter of the alphabet. For example: C – cooking, cutlery, cleaning, cabinets, containers (for trash), canned goods, cooling, cost consciousness, etc.

A \_\_\_\_\_

B \_\_\_\_\_

C \_\_\_\_\_

D \_\_\_\_\_

E \_\_\_\_\_

F \_\_\_\_\_

G \_\_\_\_\_

H \_\_\_\_\_

I \_\_\_\_\_

J \_\_\_\_\_

K \_\_\_\_\_

L \_\_\_\_\_

M \_\_\_\_\_

N \_\_\_\_\_

O \_\_\_\_\_

P \_\_\_\_\_

Q \_\_\_\_\_

R \_\_\_\_\_

S \_\_\_\_\_

T \_\_\_\_\_

U \_\_\_\_\_

V \_\_\_\_\_

W \_\_\_\_\_

X \_\_\_\_\_

Y \_\_\_\_\_

Z \_\_\_\_\_

## **ACTIVITY 4 Third Home: Finding a Place in the Community**

*Note: Activities 2-4 explore each of the “three homes” in greater detail than in Activity 1. It is recommended that these three activities be presented as a “package” in order for the training to be most effective.*

Purpose: To identify various ways and means for outreach workers to help clients experience a greater sense of place and belonging in the community

Time: 15-20 minutes

Materials: Flipchart, markers

Preparation:

Review the Three Homes handout from Activity 1 in this section, paying particular attention to the section on the “third home.”

Procedure:

1. Give a brief review as needed of the “third home” concept and state the purpose of this activity as noted above. Emphasize the importance for people who have experienced homelessness to be able to be restored to, or discover for the first time, a sense of place and belonging in the larger community.

2. Begin by having the group identify various ways one might participate in the life of a community including making use of resources and services. Write these on a flipchart. Examples may include: education, using transportation, employment, volunteering, parks and recreation, purchasing food and goods, accessing health and social services, religious affiliations, being a neighbor, responsibilities of citizenship, advocacy, political involvement, participation in organizations/clubs, travel, the arts, participation in community events, etc.

3. After creating a representative list, choose several of the topics to discuss in greater detail. With each topic, invite participants to think of specific options or ways by which outreach workers might assist clients in becoming more “at home” in the community in which they live. Below are some suggested questions you might ask to jump-start the discussion:

- How would you explain to a client who has just moved into an apartment what it means to be a “good neighbor” to those who live next door or in the same building?
- How would you explain what it means to be a “good neighbor” or “responsible citizen” in the larger neighborhood or community?
- Where are the best and most affordable places to shop for groceries, clothing, household items, etc. in the community?
- What are the best options for getting around? How does the public transportation system work?

- What employment opportunities exist? Where are good places in the community to work as a volunteer?
- Where are good places to go play? What are the more appealing and affordable recreation opportunities available?
- How does one go about signing up to take classes, get a GED, learn a hobby, or learn a trade?
- What opportunities exist in the community for lower income people to express themselves artistically?
- Is there a place where community members can garden if they don't have access to their own land?
- Which religious or civic groups are most welcoming to lower income people?
- And so forth ...

4. Close the activity by reemphasizing the importance of the role of the worker throughout the outreach and engagement relationship, and especially in the mutuality phase, to pay attention to helping clients find a rightful place in the community.



## **6C: Transition and Closure**

### **Purpose**

To acknowledge and prepare for the transition and closure phase of the worker-client relationship

### **Recommendations for Instructors**

The learning activities in this section are designed to engage participants with the subject material using informative and interactive approaches. Instructors will need to determine which, if not all, of these activities to carry out depending on a) participants' learning needs and interests, b) the focus of the training, and c) time available.

Instructors are encouraged to prepare for each activity by reviewing the handouts to be given to participants and by reading the recommended resource papers and materials that are listed. These papers and materials, along with other relevant resources, will provide useful background information to assist in fulfilling the purpose of this section. The amount of time suggested for each activity should be adjusted as needed.

## **ACTIVITY 1 Issues in Transition and Closure**

Purpose: To increase awareness of the challenges and opportunities of transition and closure in the outreach worker – client relationship

Time: 25-30 minutes

Materials: None

### Preparation:

The need to bring relationships to an endpoint happens for various reasons in outreach. Clients choose to move on, workers leave or change roles in their jobs, programs lose funding or change directions that affect the nature of the worker-client relationship, or some other adverse event occurs. Ideally, the need for transition and termination of the relationship evolves from a voluntary, mutually agreed upon plan that marks the client's need and readiness to move on – not unlike a graduation. Unfortunately, this is often the exception but nonetheless remains an important goal of outreach.

Bringing a relationship to closure is an often-ignored aspect of outreach work because so much emphasis is rightly placed on building relationships. However, for the benefit of both the client and the outreach worker, it is important to be mindful of how that relationship changes over time and eventually is brought to a conclusion. This can be a particularly difficult issue for clients especially if they have developed a strong attachment to the worker and view her or him as one of the few people they have ever been able to trust. Issues of feeling abandoned often come up during this phase. Workers do well to help clients identify and talk about these issues.

Transition and termination can also be a challenging issue for outreach workers. Workers become attached to clients and value these relationships that have developed. Because of the investment of time and energy that has gone into these relationships, workers want to ensure their efforts will not be forsaken. They rightly want to ensure that clients will be in good hands and that other providers will be able to successfully work with them on the journey towards greater stability.

Despite the difficulties of termination, this phase can also be a time of celebrating how far clients have come and of acknowledging the importance of the client-worker relationship. This is a good time to look back and remember the “story” of the relationship. This facet of closure should not be ignored. Practicing how to “say goodbye” in healthy ways is an important life skill for all of us.

Review the handout and procedure below to prepare for this activity.

### Procedure:

1. After introducing the topic based on the comments above, facilitate a group discussion about transition and closure issues in outreach. Below are some questions to stimulate discussion. Encourage participants to share their own experiences having to do with bringing outreach relationships to closure.

- Even under the best of circumstances, it is not unusual for individuals to feel “abandoned” when they are referred on to other programs or services. What are some ways you might acknowledge and address this issue in the relationship?
- Often it is helpful for the outreach worker and the provider to whom the client is being referred to temporarily provide concurrent services and support to clients in the midst of a transition phase. How do you do this in a way that doesn’t “step on the toes” of the new provider? How do you know when to step aside?
- Outreach workers understandably become invested in ensuring clients will be in “good hands” when they are referred on to someone else. It is not uncommon for workers to have concerns about whether these individuals or programs will provide the quality of care needed. How can these concerns be alleviated so you can “let go” of your role with the client?
- What are some helpful ways for workers to deal with their own feelings of grief and loss when clients move on?
- Sometimes termination occurs unexpectedly, for example, when a client “disappears” or worse, dies. What are some helpful ways for workers to acknowledge and process their grief under such circumstances? How can colleagues be of support?
- As a part of the termination process, what are some ways in which the two of you might celebrate the progress the client has made as well as commemorating your relationship?
- In a certain sense the relationships that we develop with clients never really end. Roles and functions change, but the core relationship still remains. How might you address this matter with a client with whom you are terminating your outreach role?
- What are some rituals or symbols that might be used to mark the transition and closure of a relationship?

2. Close the discussion by summarizing the key points that were made.

3. If this activity marks the end of the training, use this opportunity to acknowledge the transition and closure process occurring between yourself and the group. Using cues from the questions above, bring about appropriate closure to the session.

## **ACTIVITY 2 Addressing Closure Concerns (Role-play)**

Purpose: To practice addressing concerns related to closure in outreach through role-playing

Time: 20 minutes

Materials: None

Preparation: Refer to Activity 1. Read the comments in the Preparation section and review the discussion questions in the Procedure section. The content of Activity 2 is similar to Activity 1 but includes role-playing in addition to discussion.

Procedure:

1. Provide a summary of the key issues related to transition and closure in outreach and invite discussion about this topic.
2. Divide the group into pairs in which one person plays the role of the outreach worker and the other the client.
3. Instruct each pair to determine at the outset the reason(s) for which the relationship is being brought to closure (e.g. client is stable and connected to mainstream care provider, client is moving away, worker is quitting job, program loses funding, etc.)
4. Have the outreach worker initiate a conversation with the client about their work together coming to a close based on the reason(s) decided upon. In the course of the dialogue, the worker should explore the following aspects of closure with the client:
  - Possible feelings of abandonment
  - Celebration of the client's progress and accomplishments
  - Remembering various aspects of the relationship
  - Grief and loss
  - Ritual or symbol to mark the transition
5. If desired, have the pairs switch roles and repeat steps #3 and #4 above.
6. Invite participants to comment on their experience of doing this role-play.
7. If this activity marks the end of the training, use this opportunity to acknowledge the transition and closure process occurring between yourself and the group.

# **APPENDIX**

# Wisdom for the Journey

Give what you have. To someone else it  
may be better than dare you think.  
**Henry Wadsworth Longfellow**

I am of the opinion that my life belongs to the community ...  
and as long as I live,  
it is my privilege to do for it whatever I can.  
**George Bernard Shaw**

Hope is not about believing that we can change things.  
Hope is believing that what we do makes a difference.  
**Vaclav Havel**

They say you can lead a horse to water, but you can't  
make him drink. But I say, you can salt the oats.  
**Madeline Hunter**

## The Broken Place

This is the daily miracle  
That glancing off each granite face  
The seed at last finds lodging  
In the broken place  
And from the heart of the cleft  
Sprouts grace, springs green.  
**Anonymous**

Listening looks easy, but it's not simple. Every head is a world.  
**Cuban Proverb**

You got to be careful if you don't know where you're going,  
because you might not get there.  
**Yogi Berra**

Everything should be made as simple as possible, but not simpler.

**Albert Einstein**

Let us not underestimate how hard it is to listen and to be compassionate. Compassion is hard because it requires the inner disposition to go with others to the place where they are weak, vulnerable, lonely and broken. But ... our spontaneous response ... is to do away with suffering by fleeing from it or finding a quick cure for it. As busy, active, relevant people we want to [make] a real contribution. This means ... doing something to show that our presence makes a difference. And so we ignore our greatest gift, which is our ability to be there, to listen and to enter into solidarity with those who suffer.

**Henri J. M. Nouwen**

If you don't believe one person can make a difference,  
you have never been in bed with a mosquito.

**Anita Roddick**

True life is lived when tiny changes occur.

**Leo Tolstoy**

Listening deescalates conflict. People who know that someone is listening to them become less fearful because they feel valued.

**Gardner C. Hanks**

All sorrows can be borne if you put them  
into a story or tell a story about them.

**Isak Dinesen**

One of the remarkable qualities of the story is that it creates space. We can dwell in a story, walk around, find our own place. The story confronts but does not oppress; the story inspires but does not manipulate. The story invites us to an encounter, a dialog, a mutual sharing.

**Henri J. M. Nouwen**

We work in an environment where trust is  
as fragile as an African violet.

**Abron Morgan**

Poverty is slavery.

**African Proverb**

We are called to heal wounds,  
to unite what has fallen apart, and  
to bring home those who have lost their way.

**Francis of Assisi**

You can look at a scar and see hurt, or  
you can look at a scar and see healing.

**Sheri Reynolds**

When spider webs unite, they can tie up a lion.

**Ethiopian Proverb**

Together we are wiser than any one of us alone.

**Source Unknown**

Never doubt that a small group of thoughtful, committed citizens can  
change the world; indeed, it's the only thing that ever has.

**Margaret Mead**

Occasionally in life there are those moments of unutterable fulfillment  
which cannot be completely explained by those symbols called words. Their  
meanings can only be articulated by the inaudible language of the heart.

**Martin Luther King, Jr.**

No act of kindness, no matter how small, is ever wasted.

**Unknown**

With a sweet tongue and kindness, you can drag an elephant by a hair.

**Persian Proverb**



Listening well is as powerful a means  
of communication and influence as to talk well.  
**John Marshall**

Ethics is how we behave when we decide we belong together.  
**David Steindl-Rast**

It is only with the heart that one can see rightly.  
What is essential is invisible to the eye.  
**Antoine de St. Exupéry from The Little Prince**

**Mother Theresa** had this on her wall...

People are often unreasonable, illogical, and self-centered;  
Forgive them anyway.

If you are kind, people may accuse you of selfish, ulterior motives;  
Be kind anyway.

If you are successful, you will win some false friends  
and some true enemies;  
Succeed anyway.

If you are honest and frank, people may cheat you;  
Be honest and frank anyway.

What you spend years building, some could destroy overnight;  
Build anyway.

If you find serenity and happiness, they may be jealous;  
Be happy anyway.

The good you do today, people will forget tomorrow;  
Do good anyway.

Give the world the best you have, and it may never be enough;  
Give the world the best you've got anyway.

You see, in the final analysis, it is between you and God;  
It never was between you and them anyway.

Always do right. This will gratify  
some people and astonish the rest.

**Mark Twain**

Of all forms of inequality, injustice in  
health care is the most shocking and inhumane.

**Martin Luther King, Jr.**

We are not victims of the (external) world, we are its co-creators.

**Vaclav Havel**

### My Dream

All people should have a house with food and water

All people should have freedom of speech

All people should be able to go to the doctor

All people should be able to have a job

All people should have peace

All people who do, or did, drugs or drink should be helped

All people should have friends

I also think that people shouldn't make fun of other people because of their color  
Because we all bleed the same color and that's what matters.

**Andre (boy staying in homeless shelter)**

The finest act of love you can perform is not an act of service,  
but an act of contemplation, of seeing. When you serve ...  
you help, support, comfort, alleviate pain.

When you see (others) in their inner beauty and goodness  
you transform and create.

**Anthony DeMello**

The rush and pressure of modern life are a form, perhaps the  
most common form, of its innate violence. To allow oneself to be  
carried away by a multitude of conflicting concerns, to surrender  
to too many projects, to want to help everyone in everything is  
to succumb to violence. More than that, it is cooperation in violence.

The frenzy of the activist neutralizes one's work for peace.  
It destroys the fruitfulness of one's work, because it kills the root  
of inner wisdom, which makes work fruitful.

**Thomas Merton**

Forgiveness is the fragrance of the violet that  
clings fast to the heel that crushed it.  
**George Roemisch**

A Blessing

May you be blessed  
With discomfort at easy answers,  
Half-truths, and superficial relationships,  
So that you will live  
Deep in your heart.

May you be blessed  
With anger at injustice, oppression, and  
Exploitation of people and the earth  
So that you will work for  
Justice, equity, and peace.

May you be blessed  
With tears to shed for those who suffer  
So you will reach out your hand  
To comfort them and  
Change their pain into joy.

And may you be blessed  
With the foolishness to think  
That you can make a difference in the world,  
So you will do the things  
Which others say cannot be done.  
**Source Unknown**